HEALTH SERVICES

Budget Summary

Fund	2014-15 Base Year Doubled	2015-17 Governor	2015-17 Jt. Finance	2015-17 Legislature	2015-17 Act 55	Act 55 Change Over Base Year Doubled Amount	Percent
GPR	$6,731,858,200	$7,394,596,200	$7,390,121,900	$7,390,121,900	$7,389,441,300	$657,583,100	9.8%
FED	10,583,392,000	11,624,989,400	11,664,507,100	11,664,507,100	11,664,507,100	1,081,115,100	10.2
PR	1,927,108,200	2,153,278,200	2,291,807,000	2,291,807,000	2,291,807,000	364,698,800	18.9
SEG	1,619,351,600	1,517,496,800	1,558,395,900	1,558,395,900	1,558,395,900	- 60,955,700	- 3.8
TOTAL	$20,861,710,000	$22,690,360,600	$22,904,831,900	$22,904,831,900	$22,904,151,300	$2,042,441,300	9.8%

FTE Position Summary

Fund	2014-15 Base	2016-17 Governor	2016-17 Jt. Finance	2016-17 Legislature	2016-17 Act 55	Act 55 Change Over 2014-15 Base
GPR	2,624.91	2,545.73	2,536.63	2,536.63	2,536.63	- 88.28
FED	1,254.29	1,217.71	1,208.31	1,208.31	1,208.31	- 45.98
PR	2,313.85	2,355.61	2,357.61	2,357.61	2,357.61	43.76
SEG	2.00	2.00	2.00	2.00	2.00	0.00
TOTAL	6,195.05	6,121.05	6,104.55	6,104.55	6,104.55	- 90.50

Budget Change Items

Medical Assistance -- General

OVERVIEW OF MEDICAL ASSISTANCE (MA) AND RELATED PROGRAMS

The Department of Health Services (DHS) administers multiple health and human service programs. The largest of these is the state's medical assistance (MA) program that provides acute medical and long-term care services to eligible individuals. MA includes BadgerCare Plus for low-income individuals and families, and Medicaid coverage for elderly, blind and disabled (EBD) individuals, and various related programs. This item presents an overview of the budget for MA and related programs, excluding SeniorCare, under Act 55.

The table on the following page shows base funding for the program, estimates of the amounts that will be needed to fund MA benefits in the 2015-17 biennium without any program

changes (the program's "cost-to-continue"), and funding changes associated with program changes enacted in Act 55, by state fiscal year and fund source. MA is supported by state general purpose revenue (GPR), federal matching funds (FED), three segregated (SEG) funds (the MA trust fund, the hospital assessment trust fund, and the critical access hospital assessment trust fund), and various sources of program revenue (PR), such as drug manufacturer rebates.

The SEG amounts in this table are adjusted to correct a "double-count" that occurs when funds are transferred to the MA trust fund from the hospital and critical access hospital trust funds. The unadjusted SEG base funding is $809,347,200 SEG, which includes double-counted amounts of $145,219,800 SEG from the hospital assessment trust fund and $1,859,300 SEG from the critical access hospital assessment fund. The SEG cost-to-continue lines in this table include the amount shown in the MA cost-to-continue item, and an adjustment to account for the interaction between this SEG double count and changes in the MA federal matching rate.

The table includes a GPR funding increase and corresponding SEG reduction associated with exempting certain facilities from the nursing home bed assessment. The Governor's partial veto deleted this provision. However, instead of reducing GPR funding associated with the exemption, the Governor's partial veto reduced GPR funding that supports the general program operations of health services facilities for mental health and developmental disabilities [see item 8 under "Health Services -- Medical Assistance -- Long-Term Care"].

Summary of Medical Assistance Benefits -- Act 55

	GPR	FED	PR	SEG	Total
Base Funding	$2,517,510,500	$4,652,604,700	$580,166,900	$662,268,100	$8,412,550,200
			2015-16		
Cost-to-Continue	$251,656,900	$451,186,800	$121,579,400	-$35,912,600	$788,510,500
Program Changes					
Children's Long-Term Services - Reduce Waitlists	$370,100	$516,200	$0	$0	$886,300
Dental Services Pilot Program	0	0	0	0	0
Disproportionate Share Hospital Payments	15,000,000	20,910,900	0	0	35,910,900
Family Care, IRIS and ADRC Changes	0	0	0	0	0
Federally-Qualified Health Centers Reimbursement	0	0	0	0	0
Funeral and Cemetery Aids - Estate Recovery	0	0	0	0	0
Licensed Midwife Reimbursement	-73,000	-101,800	0	0	-174,800
Mental Health Program Consolidation	-3,744,300	0	0	0	-3,744,300
Nursing Home Bed Assessment Exemption	320,300	0	0	-320,300	0
Nursing Home Rate Increase for Acuity	0	0	0	0	0
Personal Care Independent Assessments	-3,546,900	-4,927,000	0	0	-8,473,900
Promissory Notes Counted as Resources	-100,000	-150,000	0	0	-250,000
Residential Substance Abuse Services	0	0	0	0	0
UW System Intergovernmental Transfer	-5,000,000	5,263,200	3,779,000	5,000,000	9,042,200
Subtotal	$3,226,200	$21,511,500	$3,779,000	$4,679,700	$33,196,400
Adjustment for SEG Double Count				-$13,091,800	
Total MA Benefits Funding	**$2,772,393,600**	**$5,125,303,000**	**$705,525,300**	**$617,943,400**	**$9,221,165,300**
Change to Base					
Amount	$254,883,100	$472,698,300	$125,358,400	-$44,324,700	$808,615,100
Percent	10.1%	10.2%	21.6%	-6.7%	9.8%
			2016-17		
Cost-to-Continue	$397,237,600	$492,013,800	$186,422,700	-$34,380,300	$1,041,293,800
Program Changes					
Children's Long-Term Services - Reduce Waitlists	$382,000	$530,900	$0	$0	$912,900
Dental Services Pilot Program	5,430,000	8,350,000	0	0	13,780,000
Disproportionate Share Hospital Payments	15,000,000	20,842,300	0	0	35,842,300
Family Care, IRIS and ADRC Changes	-6,000,000	-8,336,900	0	0	-14,336,900
Federally-Qualified Health Center Reimbursement	-3,434,900	-5,548,000	0	0	-8,982,900
Funeral and Cemetery Aids -- Estate Recovery	168,100	242,000	-410,000	0	100
Licensed Midwife Reimbursement	-219,400	-304,900	0	0	-524,300
Mental Health Program Consolidation	-7,488,500	0	0	0	-7,488,500
Nursing Home Bed Assessment Exemption	320,300	0	0	-320,300	0
Nursing Home Increase for Acuity	3,186,300	4,431,100	0	0	7,617,400
Personal Care Independent Assessments	-8,073,100	-11,141,200	0	0	-19,214,300
Promissory Notes Counted as Resources	-200,000	-300,000	0	0	-500,000
Residential Substance Abuse Services	2,154,500	3,231,800	0	0	5,386,300
UW System Intergovernmental Transfer	-5,000,000	5,263,200	3,789,700	5,000,000	9,052,900
Subtotal	-$3,774,700	$17,260,300	$3,379,700	$4,679,700	$21,545,000
Adjustment for SEG Double Count				-$17,273,100	
Total MA Benefits Funding	**$2,910,973,400**	**$5,161,878,800**	**$769,969,300**	**$615,294,400**	**$9,458,115,900**
Change to Base					
Amount	$393,462,900	$509,274,100	$189,802,400	-$46,973,700	$1,045,565,700
Percent	15.6%	10.9%	32.7%	-7.1%	12.4%
Change to 2015-16					
Amount	$138,579,800	$36,575,800	$64,444,000	-$2,649,000	$236,950,600
Percent	5.0%	0.7%	9.1%	-0.4%	2.6%

The following table shows total base and cost-to-continue funding for MA benefits for the 2015-17 biennium, by purpose or source, and the funding associated with other programmatic changes in Act 55.

MA Benefits Funding, By Purpose or Source -- Act 55

	2015-16				
	GPR	FED	PR	SEG	Total
Specific Populations - Base Funding and Cost-to-Continue					
Fee-for-Service EBD MA and IRIS	$847,994,500	$2,108,774,900	$0	$0	$2,956,769,400
Parents, Children, and Pregnant Women	664,610,300	1,082,520,100	0	0	1,747,130,400
Childless Adults	336,643,300	475,037,300	0	0	811,680,600
Foster Children	34,281,300	47,808,200	0	0	82,089,500
Family Planning Only Services Recipients	2,050,800	13,768,000	0	0	15,818,800
Well Woman MA Program	1,694,200	12,444,800	0	0	14,139,000
Children with Severe Emotional Disturbances	1,273,500	0	0	0	1,273,500
Specific Services - Base and Cost-to-Continue					
Family Care	$622,787,800	$928,668,300	$43,122,900	$0	$1,594,579,000
Long-Term Care "Legacy Waivers"	229,099,200	234,376,000	0	0	463,475,200
Federal Payments for Locally Matched Services	0	200,393,900	0	0	200,393,900
Community Options Program	28,732,500	0	0	0	28,732,500
Specific Services - Base and Cost-to-Continue					
Drug Manufacturer Rebates, Refunds, Collections	$0	$0	$526,253,800	$0	$526,253,800
Hospital Assessment Trust Fund	0	0	0	414,507,300	414,507,300
MA Trust Fund	0	0	0	351,441,900	351,441,900
Payment Recoveries	0	0	99,850,500	0	99,850,500
Revenues Transferred from UW System	0	0	17,319,100	0	17,319,100
Enrollee Premium Payments	0	0	15,200,000	0	15,200,000
Critical Access Hospital Trust Fund	0	0	0	7,485,400	7,485,400
Adjustment for SEG Double Count	0	0	0	-160,170,900	-160,170,900
Subtotal, Base and Cost-to-Continue	$2,769,167,400	$5,103,791,500	$701,746,300	$613,263,700	$9,187,968,900
Other Program Changes	$3,226,200	$21,511,500	$3,779,000	$4,679,700	$33,196,400
Total	**$2,772,393,600**	**$5,125,303,000**	**$705,525,300**	**$617,943,400**	**$9,221,165,300**

	2016-17				
	GPR	FED	PR	SEG	Total
Specific Populations - Base Funding and Cost-to-Continue					
Parents, Children, and Pregnant Women	$690,600,800	$1,040,182,800	$0	$0	$1,730,783,600
Fee-for-Service EBD MA and IRIS	874,788,000	1,976,010,100	0	0	2,850,798,100
Childless Adults	363,070,000	504,648,800	0	0	867,718,800
Foster Children	36,391,000	50,581,600	0	0	86,972,600
Family Planning Only Services Recipients	2,471,400	14,004,400	0	0	16,475,800
Hospital Diversion - Children with Severe Emotional Disturbances	1,273,500	0	0	0	1,273,500
Well Woman MA Program	921,600	12,897,700	0	0	13,819,300
Specific Services - Base and CTC					
Family Care	$668,386,700	$988,331,200	$42,669,000	$0	$1,699,386,900
Long-term Care "Legacy Waivers"	248,913,300	350,581,200	0	0	599,494,500
Federal Payments for Locally Matched Services	0	207,380,700	0	0	207,380,700
Community Options Program	27,931,800	0	0	0	27,931,800
Specific Services - Base and CTC					
Drug Manufacturer Rebates, Refunds, Collections	$0	$0	$613,033,000	$0	$613,033,000
Hospital Assessment Trust Fund	0	0	0	414,507,300	414,507,300
MA Trust Fund	0	0	0	353,537,400	353,537,400
Payment Recoveries	0	0	78,350,500	0	78,350,500
Revenues Transferred from UW System	0	0	17,337,100	0	17,337,100
Enrollee Premium Payments	0	0	15,200,000	0	15,200,000
Critical Access Hospital Trust Fund	0	0	0	6,922,200	6,922,200
Adjustment for SEG Double Count	0	0	0	-164,352,200	-164,352,200
Subtotal, Base and CTC	$2,914,748,100	$5,144,618,500	$766,589,600	$610,614,700	$9,436,570,900
Other Program Changes	-$3,774,700	$17,260,300	$3,379,700	$4,679,700	$21,545,000
Total	**$2,910,973,400**	**$5,161,878,800**	**$769,969,300**	**$615,294,400**	**$9,458,115,900**

The current budgeting categories for MA benefits include payments for services to certain groups of MA recipients, payments for specific purposes, and payments to support benefits costs from certain program revenue and segregated revenue sources. The other program changes outside of the cost-to-continue were not allocated by these budgeting categories, and are shown as a separate line in the previous table (shown as "Other Program Changes"). Any expenditures associated with those changes during the 2015-17 biennium will be made from the appropriate category.

The following table shows actual and projected average monthly enrollment by major eligibility group. Individuals enrolled in Family Care and other home and community-based waiver programs are included in the "Elderly" and "Disabled" enrollment totals. The table understates the number of elderly individuals participating in MA because the Department's eligibility reports classify some individuals who are both elderly and disabled as "Disabled" to avoid duplication.

Actual and Projected Average Monthly Enrollment, by Fiscal Year

	Actual			Projected		
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
BadgerCare Plus						
Children	477,300	479,400	478,700	469,900	471,200	475,900
Parents and Caretakers	264,000	251,500	229,200	178,900	177,800	177,700
Childless Adults	21,000	20,700	21,200	146,800	159,800	162,100
Pregnant Women	28,800	20,300	39,000	20,900	20,800	21,000
Total BadgerCare Plus	791,100	771,900	768,100	816,500	829,600	836,700
% Change		-2.4%	-0.5%	6.3%	1.6%	0.9%
Elderly, Blind and Disabled (EBD)						
Elderly	36,900	35,900	35,000	33,900	32,000	30,900
Disabled						
MA Only	90,800	93,300	94,000	93,300	94,200	95,100
MA/Medicare Dual Eligibles	85,800	89,300	93,400	96,700	99,200	102,200
Subtotal, Disabled	176,600	182,600	187,400	190,000	193,400	197,300
Total EBD	213,500	218,500	222,400	223,900	225,400	228,200
% Change		2.3%	1.8%	0.7%	0.7%	1.2%
Other Groups						
Family Planning Only Services	67,300	72,900	69,800	45,300	38,900	39,300
Limited Benefit Medicare Beneficiaries	19,600	20,400	21,500	22,000	22,500	23,300
Foster Children	17,300	17,800	16,700	17,700	18,000	18,200
Well Woman MA	900	1,000	900	800	800	800
Basic Plan	3,000	1,600	800	0	0	0
Total Other	108,100	113,700	109,700	85,800	80,200	81,600
% Change		5.2%	-3.5%	-21.8%	-6.5%	1.7%
Total MA Enrollment	**1,112,700**	**1,104,100**	**1,100,200**	**1,126,200**	**1,135,200**	**1,146,500**
% Change		-0.8%	-0.4%	2.4%	0.8%	1.0%

The following table shows actual and projected SEG revenues to the MA trust fund under Act 55, which are used to offset GPR in the program. The revenue amounts shown for the hospital assessment and the critical access hospital assessment reflect the amounts deposited to the MA trust fund from these sources, not the total revenue the state collects from these assessments. This includes the effect of cost-to-continue and other programmatic changes.

Actual and Projected Medical Assistance Trust Fund Revenues
Fiscal Years 2012-13 through 2016-17

	Actual		Projected		
	2012-13	2013-14	2014-15	2015-16	2016-17
Provider Assessments					
Hospital Assessment*	$152,291,900	$151,180,300	$145,219,800	$158,277,800	$162,600,500
Nursing Home/ICF-ID Bed Assessment**	78,464,700	76,512,500	74,109,500	71,551,400	69,465,600
Ambulatory Surgical Center Assessment**	16,624,300	16,616,600	16,600,000	16,600,000	16,600,000
Critical Access Hospital Assessment*	0	2,548,200	1,859,300	1,893,100	1,751,700
Subtotal	$247,380,900	$246,857,600	$237,788,600	$248,322,300	$250,417,800
Federal MA Funds Deposited to MA Trust Fund					
Nursing Home Certified Public Expenditure Program	$47,725,500	$24,705,600	$32,131,500	$35,134,200	$35,134,200
Intergovernmental Transfer From UW System	7,331,400	15,955,100	14,419,200	17,685,300	17,685,300
Hospital Certified Public Expenditure Program	5,500,000	8,000,000	5,400,000	5,400,000	5,400,000
HealthCheck-Eligible Services Provided by Residential Care Centers	6,162,500	5,178,000	7,800,000	0	0
Subtotal	$66,719,400	$53,838,700	$59,750,700	$58,219,500	$58,219,500
Other					
Transfer from Permanent Endowment Fund	$50,000,000	$50,000,000	$50,000,000	$50,000,000	$50,000,000
Interest Paid to the General Fund	-54,200	-32,300	-$100,000	-$100,000	-$100,000
Total Revenue	**$364,046,100**	**$350,664,000**	**$347,439,300**	**$356,441,800**	**$358,537,300**

*Deposited in separate trust fund and then transferred to MATF.
**Deposited directly in MATF.

1. MA COST-TO-CONTINUE [LFB Paper 345]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$647,601,300	$2,344,200	$649,945,500
FED	913,349,100	29,851,500	943,200,600
PR	228,298,200	79,703,900	308,002,100
SEG	- 111,832,600	41,539,700	- 70,292,900
Total	$1,677,416,000	$153,439,300	$1,830,855,300

Governor: Provide $650,241,200 ($263,042,700 GPR, $356,232,900 FED, $85,233,100 PR, and -$54,267,500 SEG) in 2015-16 and $1,027,174,800 ($384,558,600 GPR, $557,116,200 FED, $143,065,100 PR, and -$57,565,100 SEG) in 2016-17 to fund projected costs of MA program benefits during the 2015-17 biennium. The funding increase is based on the administration's projections of program caseload growth, changes in the mix of services enrollees

use and the costs of providing those services (referred to as changes in service use "intensity"), and other funding changes over the remainder of state fiscal year 2014-15 and the 2015-17 biennium. It does not include programmatic changes summarized under other items.

This item includes $518,700 GPR in 2015-16 and $532,300 GPR in 2016-17 for adult protective services associated with the expansion of Family Care that this office does not normally include when presenting MA program benefits. The cost-to-continue line in the first table of the previous item does not include these GPR amounts, and adjusts the SEG amount to account for the double-counted transfers to the MA trust fund.

Joint Finance/Legislature: Increase funding in the bill by $138,787,800 (-$10,867,200 GPR, $94,953,900 FED, $36,346,200 PR, and $18,354,900 SEG) in 2015-16, and $14,651,500 ($13,211,400 GPR, -$65,102,400 FED, $43,357,700 PR, and $23,184,800 SEG) in 2016-17. This reestimate reflects updated estimates of MA benefits costs in the 2015-17 biennium, and the budgeting of unexpended drug settlement funds (projected to equal $21,500,000 PR at the end of 2014-15) in the Medicaid program in 2015-16 to supplant GPR funding.

Factors Contributing to GPR Cost-to-Continue. After action by the Joint Finance Committee, and passed by the Legislature, Act 55 increases MA benefits funding by $649.9 million GPR to fully fund the program's cost-to-continue in the 2015-17 biennium. The following tables present two ways of considering this change to base funding.

The first table shows the cost-to-continue separated by GPR program expenditure category, including changes allocated to major eligibility categories. These categories correspond to those shown in the second table of the previous item. The funding changes shown in this table represent the increase or decrease in the amounts budgeted in 2014-15 under 2013 Act 20, rather than change to actual expenditures in each category.

Biennial Cost-to-Continue GPR Funding
By Expenditure Category
($ in Millions)

	Biennial Amount
Childless Adults	$361.6
Parents, Children and Pregnant Women	236.3
Family Care	54.7
EBD Medicaid and IRIS - Fee-for-Service	31.8
Long-Term Care "Legacy Waivers"	19.7
Community Options Program - Family Care	11.7
Foster Children	7.9
Family Planning Only Services Recipients	4.8
Adult Protective Services	1.1
Well Woman MA Program	-7.9
Community Options Program - Counties	-11.7
Drug Settlement Revenues	-21.5
Wisconsin Medicaid Cost Reporting	-38.5
Total	$649.9

The reduction in Well Woman MA GPR expenditures is due to an increase in the federal matching rate for that program, which increases available federal funds to offset GPR expenditures. The bill would make no programmatic changes to the Well Woman MA program.

The following table presents the $649.9 million GPR cost-to-continue, by the factors contributing to that increase. These factors include the following: (a) caseload growth above 2013 Act 20 estimates; (b) increases in managed care and fee-for-service intensity; (c) increases in "clawback" payments to the federal government under a federal formula to partially finance Medicare Part D; (d) decreases in federal matching funds due to reductions in the state's formula-based federal medical assistance percentage (FMAP); (e) additional costs associated with the excise tax on health maintenance organizations (HMOs) in the federal Patient Protection and Affordable Care Act; (f) decreases in projected SEG revenues to the MA trust fund that offset GPR spending; (g) full funding of the state's costs of providing the comprehensive community services (CCS) mental health benefit; (h) fully funding the cost of services provided by federally-qualified health centers (FQHCs); (i) increases in Medicare premiums paid by the MA program on behalf of dually-eligible individuals; (j) increases in costs for Care4Kids, a managed care program to coordinate care for foster children; (k) increases associated with non-emergency medical transportation; (l) savings associated with the expansion of Family Care to seven counties in northeastern Wisconsin; (m) available funds paid by drug manufacturers for settlement of lawsuits alleging improper charges for MA-covered prescription drugs; and (n) other factors.

Factors Contributing to GPR Increase
($ in Millions)

	Biennial Amount
Caseload Growth	$138.6
Managed Care Intensity	99.5
Prescription Drug Intensity	93.3
Fee-for-Service Intensity (Not including Drugs)	86.8
"Clawback" Payments to the Federal Government	68.2
FMAP Decrease	30.5
HMO Excise Tax Reimbursement	30.4
SEG Revenue Decrease	30.0
Full Funding of CCS	26.0
FQHC Reimbursement	16.1
Medicare Premiums	12.5
Care4Kids	5.6
Transportation Broker Costs	1.7
Expansion of Family Care to Northeast Wisconsin	-3.7
Drug Settlement revenues	-21.5
Other	35.9
Total	$649.9

The Legislature budgeted $21.5 million PR in drug settlement revenues, which offsets GPR expenditures. Through April, 2015, DHS had received $73.4 million in payments from drug

manufacturers to the state to settle lawsuits that alleged improper charges for Medicaid prescription drugs. The Department projected that it would need to use approximately $51.9 million of those funds to enable the Medicaid GPR budget to end the 2013-15 biennium in balance. In the absence of this one-time revenue, the GPR cost-to-continue for the 2015-17 biennium would have equaled $671.4 million.

2. SENIORCARE -- COST-TO-CONTINUE [LFB Paper 346]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$5,958,000	- $2,606,900	$3,351,100
FED	11,232,900	- 3,831,300	7,401,600
PR	35,125,400	- 6,480,300	28,645,100
Total	$52,316,300	- $12,918,500	$39,397,800

Governor: Provide $20,069,200 ($1,644,100 GPR, $4,221,500 FED, and $14,203,600 PR) in 2015-16 and $32,247,100 ($4,313,900 GPR, $7,011,400 FED, and $20,921,800 PR) in 2016-17 to fund the difference between base funding for SeniorCare benefits and the administration's estimates of projected costs to fully fund the program, without program changes, in the 2015-17 biennium. SeniorCare provides drug benefits for Wisconsin residents over the age of 65 who are not eligible for Medicaid drug benefits.

The program is supported with a combination of state funds (GPR), federal funds the state receives under an MA demonstration waiver (FED), and program revenue (PR) from rebate payments DHS collects from drug manufacturers. The program has four income eligibility categories, each with different requirements for deductibles and with different allocations of program costs among the fund sources.

The funding increase reflects the administration's assumptions for enrollment, distribution of enrollees among eligibility categories, cost per enrollee, federal matching percentages, and drug rebate revenue estimates. The administration projects that SeniorCare enrollment, absent any other changes to the program, would increase by 1% annually, and that the distribution of enrollees among the program's four eligibility categories would match the distribution of enrollees from the final month of 2013-14. Based on recent increases in average program costs, the average cost per enrollee is projected to increase by 10.3% annually from the 2013-14 actual cost over the three-year period from 2014-15 through 2016-17.

Although total SeniorCare expenditures are projected to increase over the three-year period under this item, the percentage of benefits costs funded by drug rebate revenue is expected to also increase, which would mitigate the impact on GPR and FED costs.

Joint Finance/Legislature: Reduce funding by $5,097,900 (-$1,028,500 GPR, -$1,660,800 FED, and -$2,408,600 PR) in 2015-16 and by $7,820,600 (-$1,578,400 GPR, -$2,170,500 FED, and -$4,071,700 PR) in 2016-17 to reflect revised estimates for the state's federal matching percentage and program enrollment. The following table shows total funding for the 2015-17 biennium under Act 55.

	Base Funding	Cost to Continue Estimate 2015-16	Cost to Continue Estimate 2016-17	Change to Base 2015-16	Change to Base 2016-17
GPR	$19,316,000	$19,931,600	$22,051,500	$615,600	$2,735,500
FED	16,694,700	19,255,400	21,535,600	2,560,700	4,840,900
PR	50,508,800	62,303,800	67,358,900	11,795,000	16,850,100
Total	$86,519,500	$101,490,800	$110,946,000	$14,971,300	$24,426,500

3. SENIORCARE -- REQUIRED MEDICARE PART D APPLICATION AND ENROLLMENT [LFB Paper 347]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	- $15,594,000	$15,594,000	$0
FED	- 15,594,000	15,594,000	0
PR	- 66,140,100	66,140,100	0
Total	- $97,328,100	$97,328,100	$0

Governor: Require SeniorCare enrollees, as a condition of program eligibility, to apply for, and if eligible, enroll in a Medicare Part D prescription drug plan, provided that the Secretary of the U.S. Department of Health and Human Services (HHS) approves this condition of eligibility for SeniorCare. Specify that a person who is already enrolled in SeniorCare on the effective date of the bill is not required to comply with this provision until January 1, 2016.

Reduce funding for the program by $32,442,700 (-$5,198,000 GPR, -$5,198,000 FED, and -$22,046,700 PR) in 2015-16 and $64,885,400 (-$10,396,000 GPR, -$10,396,000 FED, and -$44,093,400 PR) in 2016-17 to reflect this change. The estimated savings are based on an assumption that a portion of enrollees' drug costs that are currently paid by SeniorCare would instead be paid by Part D plans.

The state receives federal Medicaid matching funds for SeniorCare enrollees with household incomes below 200% of the federal poverty level, under conditions of a Medicaid waiver approved by HHS. This item would make the SeniorCare eligibility change contingent on the approval of the new Medicare Part D enrollment requirement in the state's waiver agreement.

Under Medicare Part D, a person who attains the age of 65 years old and who does not either enroll in a Part D prescription drug plan (including a Medicare Advantage plan that provides prescription drug coverage), or else have other "creditable coverage" for prescription drugs, incurs a premium penalty (a monthly add-on to the baseline premium) if he or she later purchases a Part D plan. Since SeniorCare is considered creditable coverage for the purpose of Medicare Part D, a SeniorCare enrollee does not currently need to also purchase a Part D plan to avoid future penalties. Under this item, all SeniorCare enrollees would be required to also purchase a Part D plan as a matter of state law.

Joint Finance/Legislature: Delete provision.

4. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS [LFB Paper 348]

GPR	$30,000,000
FED	41,753,200
Total	$71,753,200

Governor: Provide $35,910,900 ($15,000,000 GPR and $20,910,900 FED) in 2015-16 and $35,842,300 ($15,000,000 GPR and $20,842,300 FED) in 2016-17 to fund one-time disproportionate share hospital (DSH) payments in the 2015-17 biennium.

Direct the Department to distribute DSH payments according to a formula, as described below, if approved by the U.S. Department of Health and Human Services (HHS), or according to alternative formula negotiated with HHS, subject to approval by the Joint Committee on Finance under a 14-day passive review process.

Specify that a hospital may qualify for a DSH payment if it meets the following criteria: (a) it is located in Wisconsin; (b) it provides a wide array of services, including services provided through an emergency department; (c) the number of inpatient days for MA recipients at the hospital was at least 6% of total inpatient days at that hospital during the most recent year for which such information is available; and (d) it meets all applicable requirements under federal law relating to eligibility for DSH payments.

Require the Department, subject to federal approval, to distribute the total amount of DSH funding available in each year by utilizing a fee-for-service add-on percentage that increases as the hospital's percentage of MA recipient inpatient days increases, subject to a limit established so that at least one of the following is true: (a) no single hospital receives more than $2,500,000; and (b) the amount of the payment is in accordance with federal rules concerning the hospital-specific limit.

Specify that if the Department needs data to calculate the DSH payments other than data available from the Medicaid Management Information System, the fiscal survey data, or the federal Centers for Medicare and Medicaid Services public records, the Department shall collect the necessary data from hospitals.

Require DHS to seek any necessary federal approval for the DSH payment methodology described above, and to implement the methodology if such approval is received. In addition, in the event DHS negotiates a DSH payment methodology that differs from that described above, require DHS to submit the terms of that methodology to the Joint Committee on Finance for approval under a 14-day passive review process before DHS can implement that payment methodology.

The DSH payment requirement established under this item is similar, although not identical, to a requirement included in the 2013-15 biennial budget act. Although the amount of GPR funds provided for the payments would be the same ($15,000,000 annually), the total amount of the payments would be slightly lower, reflecting a lower anticipated federal medical assistance matching percentage (FMAP) received on the state funds. In addition, while the formula established for the 2013-15 biennium specified that the payment would increase at a 0.75 proportionate rate with the MA inpatient day percentage, the bill would specify only that the add-on percentage used for the 2015-17 biennial distribution must increase as the MA inpatient

day percentage increases, without establishing a specific coefficient.

Joint Finance/Legislature: Specify that payments are to be made annually on an ongoing basis. Require the Department to make total payments equal to the sum of $15,000,000 GPR and the amount of federal matching funds received on the GPR funds.

In addition, make the following changes at the request of the administration: (a) modify the provision pertaining to the two conditions for the maximum payment received by a hospital (no more than $2,500,000 or in accordance with federal rules concerning the hospital-specific limit), to specify that the payment maximum must meet both conditions, instead of either condition; and (b) delete language describing the payments as "an addition to the supplemental funding" on the grounds that DSH payments are considered a hospital supplemental payment, rather than an addition to supplemental payments.

[Act 55 Section: 1791r]

5. REIMBURSEMENT RATES FOR FEDERALLY QUALIFIED HEALTH CENTERS [LFB Paper 349]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	- $9,912,300	$6,477,400	- $3,434,900
FED	- 14,868,500	9,320,500	- 5,548,000
Total	- $24,780,800	$15,797,900	- $8,982,900

Governor: Reduce funding for MA benefits by $7,245,800 (-$2,898,300 GPR and -$4,347,500 FED) in 2015-16 and $17,535,000 (-$7,014,000 GPR and -$10,521,000 FED) in 2016-17 to reflect the administration's estimates of cost savings that would result by reimbursing federally-qualified health centers (FQHCs) for services they provide to MA recipients at the federal prospective payment system (PPS) rate, rather than at each FQHC's "reasonable cost." DHS estimates that the MA program will expend approximately $159.5 million (all funds) to reimburse FQHCs for MA-eligible services in 2014-15.

Federal law requires that state MA programs reimburse FQHCs for services they provide to MA recipients, at a minimum, at the PPS rate. The PPS rate is specific to each FQHC, and equals the per-visit cost at an FQHC in 2000, adjusted in subsequent years by a measure of medical cost inflation and any changes in that FQHC's scope of services. States may choose an alternate payment method, and Wisconsin currently reimburses FQHCs at 100% of their costs.

Under the bill as introduced, the administration planned to transition to the PPS payment structure over a three-year period. This would have effectively reduced each FQHC's reimbursement rate by an amount equal to one-third of the difference between their reasonable cost and their PPS rate in each of state fiscal years 2015-16, 2016-17, and 2017-18.

Joint Finance/Legislature: Require DHS to do all of the following: (a) reimburse FQHCs, for services provided prior to July 1, 2016, under the methodology in effect on January

1, 2015; (b) reimburse FQHCs for services provided on or after July 1, 2016, at a payment system based on the Medicaid PPS, with a three-year phase-in for new rates (effective for fiscal years 2016-17, 2017-18, and 2018-19); and (c) consult with FQHCs as it develops this system. Increase MA benefits funding by $7,245,800 ($2,898,300 GPR and $4,347,500 FED) in 2015-16, and $8,552,100 ($3,579,100 GPR and $4,973,000 FED) in 2016-17 to reflect the one-year delay of implementation of the PPS system.

[Act 55 Section: 1791p]

6. INDEPENDENT ASSESSMENT REQUIREMENT FOR PERSONAL CARE SERVICES [LFB Paper 350]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
GPR	- $7,550,100	0.50	- $1,000,000	0.00	- $8,550,100	0.50
FED	- 11,998,300	0.50	- 1,000,000	0.00	- 12,998,300	0.50
Total	- $19,548,400	1.00	- $2,000,000	0.00	- $21,548,400	1.00

Governor: Reduce funding by $4,412,700 (-$1,516,300 GPR and -$2,896,400 FED) in 2015-16 and by $15,135,700 (-$6,033,800 GPR and -$9,101,900 FED) in 2016-17 and provide 1.0 position (0.5 GPR position and 0.5 FED position), beginning in 2015-16, to reflect the administration's estimate of net savings that would result by requiring, prior to an MA recipient receiving personal care services on a fee-for-service basis, that an entity that does not oversee, manage, or provide the personal care services conduct an assessment to determine the amount and frequency of services the individual requires.

Personal care services are medically-oriented activities related to assisting beneficiaries with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These activities may include daily living tasks, such as eating, dressing, bathing, and meal preparation. Under current practice and administrative code, a registered nurse employed by, or under contract with the personal care agency conducts an assessment to determine the recipient's abilities and needs in order to develop a plan of care.

The Department assumes that requiring an independent assessment of personal care needs would reduce the amount of personal care services provided, resulting in benefit cost savings. The fiscal effect of this initiative is the net effect of reducing MA benefits funding to reflect estimated savings, and increasing administrative funding for DHS to implement this policy.

Joint Finance/Legislature: Reduce funding by $1,000,000 GPR and $1,000,000 FED in 2015-16 to reflect a delayed starting date for the assessment contract.

The following table summarizes the funding changes under this item.

	2015-16	2016-17
MA Benefits Funding		
GPR	-$3,546,900	-$8,073,100
FED	-4,927,000	-11,141,200
Total	-$8,473,900	-$19,214,300
Program Administration		
State Operations -- GPR	$30,600	$39,300
State Operations -- FED	30,600	39,300
Contracted Services -- GPR	1,000,000	2,000,000
Contracted Services -- FED	1,000,000	2,000,000
Total Administration	$2,061,200	$4,078,600
Net Change		
GPR	-$2,516,300	-$6,033,800
FED	-3,896,400	-9,101,900
All Funds Net Change	-$6,412,700	-$15,135,700

7. INTERGOVERNMENTAL TRANSFER FROM UW SYSTEM

SEG-REV	$10,000,000
GPR	- $10,000,000
FED	10,526,400
PR	8,095,100
SEG	10,000,000
Total	$18,621,500

Governor/Legislature: Provide $9,305,400 (-$5,000,000 GPR, $5,263,200 FED, $4,042,200 PR and $5,000,000 SEG) in 2015-16 and $9,316,100 (-$5,000,000 GPR, $5,263,200 FED, $4,052,900 PR, and $5,000,000 SEG) in 2016-17 to reflect the net effect of increasing the estimated amount of revenue the UW System would transfer to the MA trust fund under an existing intergovernmental transfer (IGT) program by $5,000,000 annually, which would replace base GPR funding budgeted for MA benefit costs. Increase in state statute, from $20,338,500 to $30,338,500, the maximum amount of revenue the UW System is required to transfer annually.

Under current law, the UW System is required to transfer no more than $20,338,500 annually in program revenue from its general operations appropriation to the MA trust fund (MATF). These funds represent a portion of the federal MA matching funds generated by the supplemental MA reimbursement rates paid to UW physicians for services they provide to MA recipients. In 2013-14, the UW System transferred approximately $16.0 million to the MATF under this provision. The administration estimates that the UW System will transfer approximately $17.7 million to the MATF in 2015-16 and 2016-17.

[Act 55 Section: 580m]

8. ENHANCED DENTAL SERVICES REIMBURSEMENT PILOT PROGRAM [LFB Paper 351]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$4,530,000	$900,000	$5,430,000
FED	6,950,000	1,400,000	8,350,000
Total	$11,480,000	$2,300,000	$13,780,000

Governor: Provide $4,530,000 GPR and $6,950,000 FED in 2016-17 to reflect the administration's estimate of additional MA benefits costs of implementing an enhanced dental services reimbursement pilot program.

Require DHS, subject to approval of the U.S. Department of Health and Human Services (HHS), to establish a pilot project under which moneys are distributed in each fiscal year to increase the MA reimbursement rate for pediatric dental care and adult emergency dental services, as defined by the Department, that are provided in Brown, Polk, and Racine Counties. Require DHS to request any waiver from, and submit any amendments to, the state MA plan to HHS necessary for the pilot project, and require the Department to implement the pilot project, beginning on the effective date of the waiver or amendment. Specify that the increased reimbursement rates would first apply to services provided on the effective date of the waiver or plan amendment.

Joint Finance/Legislature: Modify the pilot program to include dental service providers in Marathon County. Specify that the reimbursement rates established for the providers participating in the pilot program shall equal 80% of the median fee for each procedure, as reported in the most recent American Dental Association fee survey for that association's East North Central region, or the provider's usual and customary charge, whichever is less. Specify that if the median fee is not reported for a procedure then the Department shall establish a fee that approximates 80% of the median usual and customary charge for that procedure for dentists practicing in Wisconsin, but that the reimbursement paid to a provider for the procedure shall not exceed the provider's usual and customary charge for that procedure. Increase funding by $900,000 GPR and $1,400,000 FED in 2016-17 to reflect an estimate of the impact of these changes.

Specify that the enhanced MA reimbursement rates for dental services provided under the dental pilot project would be discontinued for services provided after the first day of the 37th month beginning after the effective date of the waiver or plan amendment.

Require the Department to include in any contract with a health maintenance organization that includes the provision of dental services, a requirement that the health maintenance organization reimburse providers of dental services in accordance with the enhanced reimbursement pilot program for qualifying services provided in one of the pilot counties.

Specify that dental services provided on a fee for service basis in a county that is included in the pilot program as of July 1, 2015, shall continue to be provided on a fee for service basis under the pilot program, and that dental services provided on a managed care basis in a county

that is included in the pilot program as of July 1, 2015, shall continue to be provided on a managed care basis under the pilot program.

Specify that the enhanced reimbursement procedures do not apply to dental services provided in a federal qualified health center.

Require DHS, if the pilot program is implemented, to collaborate with the American Dental Association's Health Policy Institute to prepare an evaluation of the pilot program on a quarterly basis, beginning before the first day of the fourth month beginning after the effective date of the pilot program, and require the Department to submit the report to the Joint Committee on Finance. Specify the report shall contain, at a minimum, data on the following key outcomes of interest from the pilot counties and non-pilot counties, both before and after the implementation of the pilot program: (a) dental care utilization among children and adults in both dental clinics and emergency rooms; (b) participation by dentists in the medical assistance program; (c) the fiscal impact of the pilot program, including costs and savings; (d) if feasible, a comparison of the program as administered in a fee-for-service system versus the program as administered under an HMO system; and, (e) if feasible, the impact of the program on oral health outcomes, such as MA recipients' self-reported assessment of oral health and barriers to obtaining dental care.

Veto by Governor [E-83]: Delete the following provisions: (a) the requirement that reimbursement rates under the pilot program be set at 80% of the median fee charged by dentists for each procedure, as specified in a survey conducted by the American Dental Association; (b) the requirement that the Department collaborate with the American Dental Association to produce a quarterly report on the pilot program, submitted to the Joint Committee on Finance; (c) the requirement that the pilot program end after three years; (d) the provision specifying that the enhanced reimbursement rates would first apply to services provided on the effective date of the waiver or plan amendment for the pilot program.

[Act 55 Section: 1798]

[Act 55 Vetoed Sections: 1798 and 9318(2)]

9. MA COVERAGE OF RESIDENTIAL SUBSTANCE ABUSE SERVICES [LFB Paper 352]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$3,181,100	- $1,026,600	$2,154,500
FED	4,771,700	- 1,539,900	3,231,800
Total	$7,952,800	- $2,566,500	$5,386,300

Governor: Provide $2,566,500 ($1,026,600 GPR and $1,539,900 FED) in 2015-16 and $5,386,300 ($2,154,500 GPR and $3,231,800 FED) in 2016-17 to fund the administration's estimate of the cost of extending MA program coverage to residential-based substance abuse treatment services. Include substance abuse treatment services provided by a medically

monitored treatment service or a transitional residential treatment service in the statutory list of services covered under the MA program, provided that, if federal reimbursement of such coverage requires a state plan amendment or federal waiver, that the U.S. Department of Health and Human Services approves of the amendment or waiver.

Define a "medically monitored treatment service" as a 24-hour, community-based service providing observation, monitoring, and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient. Define a "transitional residential treatment service" as a clinically supervised, peer-supported, therapeutic environment with clinical involvement providing substance abuse treatment in the form of counseling for three to 11 hours provided per week for each patient.

Under current law, the MA program covers certain day treatment services for substance abuse, as well as certain hospital inpatient services and outpatient substance abuse counseling, but does not cover treatment provided in a residential (non-hospital) setting. The administration's costs estimates assume that the MA program would begin covering residential treatment services beginning on January 1, 2016, and that approximately 800 MA recipients in 2015-16 and 1,600 MA recipients in 2016-17 would receive these services.

Joint Finance/Legislature: Specify that MA reimbursement for treatment services would be provided for dates of service no sooner than July 1, 2016, or the date the U.S. Department of Health and Human Services approves any state plan amendment or federal waiver authorizing these services, whichever is later. Reduce funding by $2,566,500 (-$1,026,600 GPR and -$1,539,900 FED) in 2015-16 to reflect this change.

[Act 55 Sections: 1808 and 1809]

10. INCLUDE DRUGS IN MANAGED CARE CONTRACTS [LFB Paper 353]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	- $930,100	$930,100	$0
FED	- 1,294,700	1,294,700	0
Total	- $2,224,800	$2,224,800	$0

Governor: Reduce MA program benefit funding by $692,800 (-$289,300 GPR and -$403,500 FED) in 2015-16 and $1,532,000 (-$640,800 GPR and -$891,200 FED) in 2016-17 to reflect an administrative initiative to include the cost of prescription drugs in managed care contracts, beginning in 2016, for all MA recipients enrolled in managed care organizations (MCOs). Under current practice, pharmacies are reimbursed for drugs they provide to MA recipients on a fee-for-service basis, even for MA recipients enrolled in MCOs. The funding reduction in this item reflects the administration's estimate that including drugs in the MCO contracts will reduce drug costs by 0.15%. The bill does not contain statutory changes associated with this initiative. The administration intends to request that the Committee delete this item from the bill.

Joint Finance/Legislature: Delete provision.

11. SERVICES PROVIDED BY CERTIFIED PROFESSIONAL MIDWIVES

GPR	- $292,400
FED	- 406,700
Total	- $699,100

Governor/Legislature: Reduce funding for MA benefits by $174,800 (-$73,000 GPR and -$101,800 FED) in 2015-16 and by $524,300 (-$219,400 GPR and -$304,900 FED) in 2016-17 to reflect estimates of net savings that would result by providing MA coverage for services provided by certified professional midwives. Add licensed midwife services provided by certified professional midwives licensed under state law to the statutory list of services covered under the state's MA program. Require DHS to submit an amendment to the state's MA plan to the U.S. Department of Health and Human Services to permit reimbursement of services provided by a certified professional midwife. Specify that this provision would take effect beginning on January 1, 2016, provided that the state receives federal approval of the amendment to its state MA plan.

The administration's savings estimate assumes that midwife services offered by a certified professional midwife will replace some MA-eligible services provided by physicians and hospitals, resulting in a net reduction in MA benefits costs. Currently, the MA program covers nurse-midwifery services, but not licensed midwife services provided by a certified professional midwife.

[Act 55 Sections: 1799 and 1807]

12. BADGERCARE PLUS COVERAGE FOR CHILDLESS ADULTS [LFB Papers 354 and 355]

Governor: Require DHS to submit to the Secretary of the federal Department of Health and Human Services (HHS) an amendment to the existing waiver of federal law that extended coverage to adults without dependent children ("childless adults") with household income of up to 100% of the federal poverty level (FPL). Require the amendment to do all the following:

a. Impose monthly premiums as determined by DHS;

b. Impose higher premiums for enrollees who engage in behaviors that increase their health risks, as determined by DHS;

c. Require a health risk assessment for all childless adults;

d. Limit a childless adult's MA eligibility to no more than 48 months, and require DHS to specify the eligibility formula in the amendment; and

e. Require, as a condition of eligibility, that a childless adult applying for or enrolled in the program submit to a drug screening assessment, and, if indicated, a drug test, as specified by DHS in the amendment.

If the HHS Secretary approves the amendment in whole or in part, require DHS to do all the following: (a) implement the changes to the program approved by the HHS Secretary, consistent with that approval; (b) identify in its quarterly report on the MA budget to the Joint

Committee on Finance any costs incurred or savings realized in the 2015-17 biennium as a result of the actions taken under these provisions, as approved by the HHS Secretary; and (c) in the agency budget request for the 2017-19 biennium, include any future fiscal impact resulting from the actions taken under these provisions, as approved by the HHS Secretary.

Repeal the current statutory provision that requires childless adults with income over 133% of the FPL to pay premiums of between 3% and 9.5% of household income.

Joint Finance/Legislature: Prior to submitting the amendment to the HHS Secretary, require DHS to submit to the Joint Committee on Finance a report that summarizes the provisions, and provides an estimate of the fiscal effect, of the proposed amendment to the waiver.

If the HHS Secretary approves the amendment in whole or in part, require DHS, before implementing the changes, to submit a report to the Joint Committee on Finance that summarizes the provisions, and provides an estimate of the fiscal effect, of the approved amendment.

Veto by Governor [E-84]: Delete the requirement that DHS submit reports to the Joint Finance Committee prior to submitting the amendment to HHS, and prior to implementing any amendment approved by HHS.

[Act 55 Sections: 1796, 1797, and 9118(6)]

[Act 55 Vetoed Section: 1797]

13. REPEAL THREE-MONTH WAITING PERIOD FOR BADGERCARE PLUS COVERAGE AFTER ENDING PRIVATE COVERAGE

Governor/Legislature: Repeal provisions that subject the following individuals to a three-month waiting period for BadgerCare Plus coverage after ending other insurance coverage without a good cause reason: (a) an individual with family income over 150% of the federal poverty level (FPL); (b) an unborn child or an unborn child's mother; (c) a pregnant woman with income over 200% of the FPL; and (d) a non-disabled, non-pregnant adult with income over 133% of the FPL, and his or her non-disabled children.

Repeal provisions that impose a three-month waiting period on the following individuals, if the federal Department of Health and Human Services approves of a DHS request to impose that waiting period: (a) a child in a household with income above 133% of the FPL; (b) a non-disabled, non-pregnant parent or caretaker relative with income above 100% of the FPL; and (c) an adult with income greater than 100% of the FPL (including a pregnant adult) who is under 26 years of age and is eligible for coverage under his or her parent's employer-sponsored insurance.

Repeal provisions defining a "good cause reason" for ending other insurance coverage for the purposes of determining who is currently subject to a three-month waiting period for BadgerCare Plus coverage.

Due to BadgerCare Plus program eligibility changes made after these current law provisions were enacted, the only individuals subject to the three-month waiting period are children at certain income levels and pregnant women in the BadgerCare Plus prenatal program.

[Act 55 Sections: 1810 thru 1813]

14. MA REIMBURSEMENT FOR VACCINES ADMINISTERED BY PHARMACISTS

Governor/Legislature: Require DHS to provide reimbursement under the MA program for vaccines administered by pharmacists who meet training requirements specified by the Department to administer vaccines, as determined by the Department, to a person six to 18 years of age, provided the U.S. Department of Health and Human Services approves an amendment to the state's MA plan. Require DHS to submit an amendment to the state MA plan to provide for such reimbursement. Require a pharmacist or pharmacy to enroll in the federal Vaccines for Children program to be eligible for MA reimbursement under this provision.

[Act 55 Section: 1801]

15. NONEMERGENCY MEDICAL TRANSPORTATION IN SOUTHEASTERN WISCONSIN

Joint Finance/Legislature: Require DHS to modify the current contract for the arrangement and reimbursement of nonemergency medical transportation services for medical assistance beneficiaries, to the extent permitted by that contract, to exclude Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha county MA beneficiaries from the contract and make alternative arrangements for the provision of nonemergency medical transportation services for beneficiaries in those counties. Specify that alternative arrangements may be made with counties, health maintenance organizations, or transportation providers. Specify that this change would apply to the contract in effect on the effective date of the bill and would take effect no later than January 1, 2016.

Veto by Governor [E-81]: Delete provision.

[Act 55 Vetoed Section: 9118(11f)]

16. AMBULATORY SURGICAL CENTER ASSESSMENT REPORT

Joint Finance/Legislature: Require DHS to annually submit a report to the Joint Committee on Finance that contains all of the following information for the prior fiscal year: (a) the total amount of revenue collected from eligible ambulatory surgical centers (ASCs) under the ASC assessment; (b) the amount each eligible ASC paid under the assessment (require DHS to specify the specialty of the center paying the assessment, but allow DHS to withhold the name of the ASC paying the assessment); (c) the total amount of money received by each managed care organization, if money was received in MA payment increases made in connection with the implementation of the assessment; (d) the total amount each managed care organization paid to

ASCs; and (e) the total amount of payment increases made in connection with the implementation of the assessment paid to eligible ASCs on a fee-for-service basis under the assessment.

In addition, require the Department of Revenue (DOR), upon the request of DHS, to provide to DHS any information in the possession of DOR that is necessary for DHS to complete the report.

Veto by Governor [C-50]: Delete provision.

[Act 55 Vetoed Section: 3483t]

17. FEDERAL MATCH FOR POISON CONTROL CENTERS

Joint Finance/Legislature: Authorize DHS to use GPR funding budgeted to support the state's poison control system as the state share for the purpose of obtaining federal matching funds available under Title 21 of the Social Security Act (the Children's Health Insurance Program, or CHIP). Modify the federal MA benefits appropriation to authorize the expenditure of these federal funds for this purpose.

The bill would maintain base funding DHS provides annually to supplement the operation of a statewide poison control program and for the statewide collection and reporting of poison control activities ($382,500 GPR annually). Under CHIP, states may submit state plan amendments to use federal funds to implement certain health services initiatives to improve the health of children, including initiatives targeting children in families with low income.

[Act 55 Sections: 688 and 4109d]

18. QUI TAM CLAIMS

Joint Finance/Legislature: Eliminate private individuals' authority to bring qui tam claims against a person who makes a false claim for medical assistance. This provision would not affect qui tam claims filed before the effective date of Act 55. Under current law, with regards to the MA program, a qui tam claim is a claim initiated by a private individual on behalf of that individual and on behalf of the state against a person who makes a false claim for medical assistance. Moneys recovered as a result of qui tam claims accrue to both the MA program and the private individual who initiated the claim. Of the recovered amounts, the private individual may be awarded attorney fees and up to 30% of the amount recovered, depending on the extent to which the private individual contributes to the prosecution of the action. The remaining amounts are recovered by the state and federal government for the MA program and attorney fees. Under current law, in addition to qui tam claims, the Wisconsin Department of Justice has independent authority to initiate a claim against a person who makes a false claim for medical assistance.

[Act 55 Sections: 945n, 3501p, 3504c, 4610f thru 4610r, 4639g, and 9318(3f)]

Medical Assistance -- Long-Term Care Services

1. CHANGES TO FAMILY CARE, IRIS, AND AGING AND DISABILITY RESOURCE CENTERS [LFB Papers 356, 357, and 358**]**

GPR	- $6,000,000
FED	- 8,336,900
Total	- $14,336,900

Governor: Reduce funding by $14,336,900 (-$6,000,000 GPR and -$8,336,900 FED) in 2016-17 to reflect changes to the Family Care program. This funding reduction reflects the Department of Administration's estimates of anticipated savings to current Family Care, IRIS, Partnership and PACE spending associated with proposed changes to the state's long-term care programs.

Under the Family Care program, managed care organizations (MCOs) provide long-term care services to elderly individuals, adults with developmental disabilities, and adults with physical disabilities. The state also offers the fee-for-service, self-directed IRIS (Include, Respect, I Self-Direct) program to provide individuals who qualify for Family Care services with an alternative to managed care. In addition to Family Care and IRIS, individuals in two counties have access to the Program of All-Inclusive Care for the Elderly (PACE), and individuals in 14 counties have access to the Family Care Partnership Program (Partnership), which provide integrated delivery of primary and acute medical care, long-term care, and prescription drug coverage.

The bill contains the following provisions.

Statewide Provision of Services. Require DHS to submit a request for a federal waiver from the U.S. Department of Health and Human Services (HHS) allowing for the administration of the Family Care program statewide by MCOs, unless DHS waives this requirement for a specific MCO. If a federal waiver is approved, require DHS to make the Family Care program available statewide by January 1, 2017, or a date determined by the Department, whichever is later. This provision does not require all eligible individuals to be enrolled by January 1, 2017, and the Department has noted that, assuming a federal waiver is approved, it intends to enroll individuals using the same 36-month enrollment phase-in as is specified under current law.

Require DHS to request a federal waiver allowing for the elimination of the competitive procurement process for MCOs, and, if approved, to contract for the statewide provision of services with any MCO that meets the statutory requirements for providing services.

Remove the statutory requirement that the Department submit proposals for Family Care expansion to the Joint Committee on Finance (JFC) for approval. Allow DHS to eliminate the community integration program (CIP), the community opportunities and recovery program (CORP), and the community options program (COP) after the Family Care program is offered to all eligible residents in a county. Modify current references in the long-term care statutes to improve consistency and reflect current practices.

Under current law, Family Care and IRIS are available in 57 counties, and will be expanded to an additional seven counties in calendar year 2015. The eight counties that will not be participating in Family Care and IRIS at the end of calendar year 2015 are Adams, Dane, Florence, Forest, Oneida, Rock, Taylor, and Vilas. The state currently provides home and community-based long-term care services to individuals in these counties through the "legacy" home and community-based waiver programs, including CIP, COP, and CORP.

Under current law, DHS awards a contract to one MCO to provide services in a geographic service region of the state, based on a competitive, sealed procurement process. If DHS proposes to contract with an entity to administer the Family Care benefit in a new geographic area, it must first submit the proposed contract, an estimated fiscal effect demonstrating that the expansion is cost neutral, documentation that the proposed expansion county consents to the expansion, the county's Family Care contribution, and the county's proposal for how it will use any county expenditure savings that result from the Family Care benefit being available in that county, to JFC, and DHS may only enter into the proposed contract if JFC approves the contract.

Self-Directed Services. Delete statutory references to the IRIS (Include, Respect, I Self-Direct) program. Require DHS to allow Family Care enrollees to self-direct services. Remove statutory references to IRIS program services offered to individuals receiving post-secondary education on the grounds of an institution, and replace with references to the self-directed Family Care program.

Primary and Acute Services in Family Care Program. Require DHS to request a waiver from HHS allowing for the inclusion of any primary and acute health services mandated under federal MA law, such as physicians' services, inpatient hospital services, and skilled nursing home services, that the Department chooses to offer as a benefit under the Family Care program. If approved by HHS, allow DHS to offer the approved services under the Family Care program.

Family Care Open Enrollment. Require DHS to request a waiver from HHS allowing enrollees to change MCOs only during a specified open enrollment period and, if approved, implement this provision.

MCO Contracts and Oversight. Require DHS to request a waiver from HHS to remove statutory requirements for MCOs under Chapter 648 ("Regulation of Care Management Organizations"), which specify the requirements for applying for, issuing, and suspending or revoking an MCO's permit, the role of the Office of the Commissioner of Insurance (OCI) and the Commissioner in regulating MCOs, reporting duties of MCOs, requirements for responsiveness of MCOs to OCI, the ability of OCI to examine, audit, or otherwise study the operations of an MCO, the responsibility of MCOs for the costs of such examinations and audits, the ability of OCI to refuse to disclose information, including reports, records, and information obtained through reports and during examinations regarding MCOs, the ability of OCI to enforce relevant regulations, processes related to disclosing management changes, protections related to enrollees of MCOs, and processes for insolvency funding of MCOs. Eliminate the transfer from OCI's general program operations appropriation to the DHS appropriation for oversight of MCOs. Repeal OCI appropriations related to the costs OCI may charge MCOs for employing

experts to examine or review transactions, and for other costs related to analysis and financial monitoring of MCOs by OCI under current law. Eliminate the appropriation related to collections of expenses for insolvent or financially hazardous MCOs. Allow OCI to apply statutory regulations related to insurance providers, including provisions related to solvency assessment, accounting and reserves, rate regulation, insurance marketing, and other general public policy provisions applicable to insurers, to MCOs. Permit OCI to promulgate rules regarding licensing MCOs as insurers and regulating the operations of MCOs as necessary. These provisions would be effective July 1, 2018.

Prohibit MCOs from investing risk reserve funds in time deposits, or in bonds or securities issued or guaranteed by the federal government or by a commission, board, or other instrumentality of the federal government.

Eliminate the requirement that, as a term of a contract with an MCO, an MCO must contract for the provision of services covered under the Family Care benefit with any community-based residential facility, residential care apartment complex, nursing home, intermediate care facility for the intellectually disabled, community rehabilitation program, home health agency, provider of day services, or provider of personal care that agrees to accept the reimbursement rate that the MCO pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria that the MCO requires of other providers with which it contracts to provide the same service. Eliminate the ability of DHS to prohibit MCOs from including provisions in contracts with Family Care service providers to return any funding for residential services, prevocational services, or supported employment services that exceed the costs of services to MCOs. These provisions would be effective July 1, 2018.

Under current law, MCOs are subject to oversight provisions enforced by OCI, including permitting, reporting, and examination requirements. Additionally, they are subject to certain restrictions on contracts with service providers specified by DHS.

ADRC Service Providers and Services. Permit DHS to contract with entities other than aging and disability resource centers (ADRCs) to perform the duties of ADRCs. Permit DHS to specify in a contract with an ADRC or agency acting as an ADRC that the entity provide any of the following services or functions: (a) information and referral services and other assistance at hours that are convenient for the public; (b) a determination of functional eligibility for Family Care; (c) within the limits of available funding, prevention and intervention services; (d) counseling concerning public and private benefits programs; (e) a determination of financial eligibility and of the maximum amount of cost sharing required for a person who is seeking long-term care services, under standards prescribed by the Department; (f) assistance to a person who is eligible for Family Care with respect to the person's choice of whether or not to enroll in an MCO and, if so, which available MCO would best meet his or her needs; (g) assistance in enrolling in an MCO; (h) transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system; and (i) a determination of eligibility for state supplemental payments, MA benefits related to the receipt of certain Social Security, Medicare, or BadgerCare Plus benefits, or for FoodShare benefits.

Under current law, individuals have access to ADRCs, which serve as a gateway for individuals who need, or expect to need, long-term care services through programs such as Family Care, IRIS, PACE, and Partnership. ADRCs are responsible for the provision of all of the services outlined above, and must provide all of their services at no cost to recipients. As of August, 2014, there were 41 ADRCs operating in Wisconsin, including 28 single county ADRCs and 13 multi-county/tribe regional ADRCs, serving all 72 counties and 11 tribes.

Currently, the contract between an ADRC and DHS assigns responsibilities to each ADRC and allows the ADRC to be reimbursed for its costs in carrying out these required functions. Counties are not expected to contribute to the cost of operating ADRCs. State funding to support ADRCs is allocated based on the estimated size of the population served in each area and estimates of the amount of time required to carry out the ADRC functions. If actual costs exceed this limit, the ADRC is responsible for those costs. Because ADRCs provide services to, and respond to, inquiries from individuals and their families regardless of MA eligibility, federal cost sharing for their operation is limited to the amount that can be documented as supporting services for MA-eligible individuals. DHS estimates that approximately 65 percent of ADRC expenditures were eligible for federal MA administrative matching funds between July 1, 2014, and October 29, 2014, meaning that approximately 32.5 percent of ADRC expenditures are currently paid by federal matching funds.

Elimination of Long-Term Care Districts, Advisory Committees, and ADRC Governing Boards. Require long-term care districts existing on June 30, 2015, to be dissolved before June 30, 2017, or before a date established by DHS, whichever is later. Prohibit any new long-term care districts from being created after June 30, 2015. Remove all statutory language regarding and references to long-term care districts, effective July 1, 2018.

Under current law, a long-term care district is a local unit of government created with the purpose of operating an MCO, an ADRC, the Partnership program, or PACE. A long-term care district is overseen by a long-term care district board, and has jurisdiction within the county or counties that created it, or the geographic area of the reservation of the tribe or band that created the district. There are currently seven long-term care districts, four of which are Family Care MCOs, one of which operates an ADRC, and two of which have no contract with DHS.

Repeal regional long-term care advisory committees. Remove all statutory references to regional long-term care advisory committees. Under current law, regional long-term care advisory committees are responsible for: (a) evaluating the performance of MCOs in the committee's region with respect to responsiveness to service recipients, number of choices available to recipients, and other issues affecting recipients, and making recommendations based on these evaluations; (b) evaluating the performance of ADRCs and making recommendations regarding their performance; (c) monitoring grievances and appeals made to MCOs; (d) reviewing utilization of long-term care services in the committee's region; (e) monitoring enrollments and disenrollments in MCOs operating in the committee's region; (f) identifying gaps in availability of services, living arrangements, and community resources and developing strategies to build capacity to provide those services; (g) performing long-range planning related to long-term care policy for individuals served by ADRCs; and (h) reporting to DHS annually regarding achievements and problems related to the provision of long-term care services in that

region.

Eliminate ADRC governing boards. Remove all statutory references to ADRC governing boards. Under current law, ADRCs have a governing board that is responsible for determining the structure, policies, and procedures of, as well as overseeing the operations of, the ADRC. In addition, the governing board is responsible for gathering information regarding the ADRC's activities, including identifying gaps in services and reporting findings to the regional long-term care advisory committee. Further, the governing board is responsible for recommending strategies for building local capacity, identifying new sources of community resources and funding, appointing members to the long-term care advisory committee, reviewing interagency agreements between ADRCs and MCOs, reviewing the number and types of grievances and appeals related to long-term care in the area served by the ADRC, and recommending system changes as appropriate.

Contingency Provision. Require that, if any of the waiver requests specified above are not approved, the Department continue to administer the Family Care benefit in accordance with current statutory requirements.

Joint Finance/Legislature: Delete all of the statutory changes recommended by the Governor. However, retain the Governor's recommendation to reduce MA benefits costs by $14,336,900 (-$6,000,000 GPR and -$8,336,900 FED) in 2016-17 to reflect savings DHS would be expected to realize in the 2015-17 biennium in providing services to MA recipients who receive long-term care services.

Require DHS to submit a request to the U.S. Department of Health and Human Services (HHS) for changes to the state's current waiver under which Family Care and IRIS operates. Require that the waiver request provide for the expansion of the Family Care program statewide. If a federal waiver is approved, require DHS to make the Family Care program available statewide by January 1, 2017, or a date determined by the Department, whichever is later. If the Department specifies a date later than January 1, 2017, require the Department to submit the date to the Legislative Reference Bureau for publication in the Wisconsin Administrative Register. If such a waiver is approved, permit the Department to expand the program statewide, notwithstanding the requirement that the Department submit proposals for Family Care expansion to the Joint Committee on Finance (JFC) for approval. Permit DHS to eliminate the community integration program (CIP), community opportunities and recovery program (CORP), and community options program (COP) after the Family Care program is available to all eligible residents in a county.

In addition to requesting the statewide expansion of Family Care, require that the waiver request include the following components: (a) specify that MA-funded long-term care consumers receive both long-term care and acute care services, including Medicare-funded services to the extent allowable by CMS, from integrated health agencies (IHAs); (b) increase the size of regions currently served by managed care entities, such that each region has sufficient population to allow for adequate risk management by IHAs; (c) specify that there shall be no less than five regions; (d) require multiple IHAs in all regions of the state; (e) require IHAs to make available a consumer-directed option under the long-term care program, under which the IHA would assist

individuals in developing individualized support and service plans, ensure that all services are paid according to the plan, and assist enrollees in managing all fiscal requirements, and which shall include, but is not limited to, the ability to select, direct, and/or employ persons offering any of the services available under the IRIS program as of July 1, 2015, and the ability to manage, utilizing the services of an IHA serving as a fiscal intermediary, an individual home and community-based services budget allowance based on a functional assessment performed by a qualified entity and the availability of family and other caregivers who can help provide needed support; (f) modify the state's long-term care programs, including allowing for audits of providers, in order to improve accountability in the provision of services; (g) establish an open enrollment period for the state's long-term care programs that coincides with the open enrollment period for the Medicare program; (h) require that rates paid to IHAs be set through an independent actuarial study; and (i) preserve the "any willing provider" provision, which requires IHAs to contract for long-term care services with any provider that agrees to accept the reimbursement rate and satisfies any qualify of care, utilization, or other criteria that the IHA requires of similar providers for the same services, for a minimum of three years in each region following the implementation date of the program in that region.

Direct DHS to consult with stakeholders, including representatives of consumers of long-term care and long-term care providers, and the public prior to developing its final waiver request to be submitted to JFC. Specify that DHS hold no less than two public hearings regarding the proposed Family Care waiver prior to its submission to JFC. In addition, require DHS to submit, as part of the MA quarterly status reports submitted by September 30, 2015, and December 30, 2015, progress reports regarding the development of the waiver proposal. Specify that the progress reports must include, but are not limited to, information regarding outcomes of discussions with stakeholders and CMS.

Additionally, require DHS to develop its final recommendations in accordance with the ten key principles determined by CMS to be essential elements of a strong managed long-term services and supports program, which include: (a) adequate planning and transition strategies; (b) stakeholder engagement; (c) enhanced provision of services in home and community-based settings; (d) alignment of payment structures with programmatic goals, including improving the health of enrollees, improving the experience of enrollees, and reducing costs through these improvements; (e) support for beneficiaries, including counseling regarding options and enrollment from an independent source at no cost to the beneficiary and the availability of ombudsman resources; (f) person-centered processes, including an option to self-direct services; (g) a comprehensive and integrated service package; (h) qualified providers; (i) participant protections, including systems to manage incidents and appeals processes for program participants; and (j) comprehensive quality assurance and oversight procedures.

Require DHS to submit a summary of the proposed concept plan associated with the waiver request to the Committee for review and approval or disapproval without changes no later than April 1, 2016, prior to the Department's submitting any proposed changes to the state's MA waiver agreements or a state plan amendment to CMS for that agency's approval. If a state plan amendment or waiver request is approved and is substantially consistent with the initial waiver application, as approved by JFC, permit the Department to, notwithstanding the current Family Care statutes, implement any programmatic changes in accordance with the approved waiver. If

the state plan amendment is not approved or if a waiver that is substantially consistent with the initial waiver request, as approved by JFC, is not approved, the waiver may not be implemented, and the Family Care program shall continue to operate in accordance with statutes in effect on July 1, 2015. Require the Department include in its 2017-19 biennial budget request any proposed statutory changes necessary to conform the statutes to the approved waiver or state plan amendment.

Specify that language under s. 46.2895 of the statutes relating to tribal or band long-term care districts shall be maintained until a waiver from CMS for the provision of tribal long-term care services relating to those long-term care districts is approved.

Require long-term care advisory committees to, in addition to their current statutory responsibilities, provide for review and assessment of the self-directed services option.

Specify that a long-term care district, defined under s. 46.2895 of the statutes, is permitted to operate a health maintenance organization in accordance with state law.

Require DHS to evaluate the functional screen and options counseling for reliability and consistency among ADRCs, and to provide a report regarding these activities by January 1, 2017.

Specify that the Department assess which responsibilities of ADRC governing boards are duplicative with current Department procedures, and propose changes to the statutory requirements of these boards that remove duplication to JFC no later than July 1, 2016.

Require DHS to study the integration of income maintenance consortia and ADRCs, and to present a report to JFC no later than April 1, 2016 with recommendations regarding potential efficiencies that may be gained, if any, from the integration of these entities, as well as whether such a merger would be appropriate in light of the responsibilities of each entity.

Veto by Governor [E-73]: Delete the requirement that the waiver request include the following provisions: (a) that there be at least five regions in which long-term care services are provided; (b) that the long-term care program's open enrollment period coincide with the Medicare open enrollment period; and (c) that rates paid to IHAs are set through an independent, actuarial study.

[Act 55 Sections: 1533, 1569b, 1618c, 9118(9), 9118(9q), and 9418(6)]

[Act 55 Vetoed Section: 9118(9)]

2. CHILDREN'S COMMUNITY OPTIONS PROGRAM [LFB Paper 359]

Governor: Create a children's community options program (CCOP) by repealing the family support program (FSP) and consolidating funding currently budgeted for that program and funding that currently supports long-term care services for children under the community options program (COP), effective January 1, 2016.

Currently, FSP funds services that help children with severe disabilities remain in their homes. The program provides up to $3,000 per year in services and goods to eligible families, and additional amounts that may be provided with DHS approval. While income is not a condition of eligibility for the program, families with income greater than 330% of the federal poverty level are required to share in the cost of program services based on a sliding scale.

CCOP would provide services to children previously served under FSP. Funding for FSP ($2,544,500 GPR in 2015-16 and $5,089,000 GPR in 2016-17) would be transferred to an appropriation that supports the community options program and long-term support services, and would be used, together with base funds currently used to serve children under the current community options program (approximately $4.0 million GPR in calendar year 2013) to fund CCOP.

The bill contains the following provisions.

Eligibility. Direct DHS to allocate funds to county or private nonprofit agencies to provide long-term community support services to eligible children who have a disability. For these purposes, define a "child" as a person under 22 years of age and who is not receiving services in, or on a waiting list for, an adult long-term care program. Define a "disability" as a severe physical, developmental, or emotional impairment that is diagnosed medically, behaviorally, or psychologically, characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation, or other services, and which has resulted or is likely to result in substantial limitation to at least two of the following areas: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; and (e) self-direction. Require that an assessment be conducted for any child seeking CCOP services, within the limits of state and federal funds and fee collections.

Direct DHS to create a sliding scale formula for fees chargeable for conducting an assessment, developing a case plan, and providing long-term community support services, based on a child's ability to pay, unless prohibited under federal Medicaid law. Require counties to require children or their parents or guardians applying for CCOP to provide, at the time of application or for children currently receiving such services, a declaration of income on a form prescribed by DHS and a declaration of costs paid annually for care and services related to the child's disability or special need. From this information, direct the county department to determine the amount of the fee for CCOP services, and require the county department to require payment by the child or parent or guardian of 100 percent of the specified fee. Require that the county use all fee revenue to pay for long-term community support services for children eligible for CCOP.

Require participating counties to ensure individuals receiving CCOP services meet applicable eligibility requirements, through use of a form or other procedure provided by DHS. Specify that, within the limits of available state and federal funds reimbursed by DHS and CCOP fee revenue, the county department or private, nonprofit agency must provide CCOP services to all eligible children, excluding room and board expenses. Permit DHS to disallow reimbursement for services provided to children who do not meet CCOP or other eligibility requirements established by DHS. Specify that a child who is denied eligibility for services or whose services

are reduced or terminated is permitted a hearing with DHS based on statutory requirements for administrative hearings, unless services are denied, reduced, or terminated due to lack of funding.

Responsibilities of DHS. Require DHS to develop guidelines for implementing CCOP, and to review and approve or disapprove each county department selected to administer the program. Provide that DHS must approve or reject the community options plan of each participating county, based on criteria DHS develops in consultation with representatives of counties, hospitals (defined as any building, structure, institution or place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment of and medical or surgical care for three or more nonrelated patients, suffering from illness, disease, injury or disability, whether physical or mental, and including pregnancy and regularly making available at least clinical laboratory services, and diagnostic X-ray services and treatment facilities for surgery, or obstetrical care, or other definitive medical treatment), other institutional settings, and recipients of children's community support services, which address cost-effectiveness, scope, feasibility, and impact on quality and appropriateness of health and social services, and provide counties with maximum flexibility to develop programs that address local needs. Require DHS to periodically monitor program implementation.

Require DHS to, following consultation with representatives of counties, hospitals, and individuals who receive services under CCOP, establish minimum requirements for the provision of services, including standards for care, timeliness for performance of duties, and acceptable caseload size, as well as a reasonable schedule for phasing in these minimum requirements. In addition, require DHS to provide technical consultation and assistance to the administrator of CCOP regarding these minimum requirements. Specify that these minimum requirements and schedule do not need to be promulgated as rules.

Provide that, if DHS has a waiver from the federal requirement to review a county department or private, nonprofit agency's plans of care for each individual receiving home or community-based services because DHS or the agency has implemented effective quality assurance systems based on evaluations of the adequacy, safety, and comprehensiveness of individual care plans and services, the waiver applies to the care plans for children enrolled in CCOP.

Advisory Committee. Require participating counties to appoint members to an advisory committee or appoint an existing advisory committee to serve as the CCOP advisory committee, whose responsibilities include assisting in developing the program plan and monitoring the program. The membership of this committee would include, but would not be limited to: (a) a majority of the committee membership composed of parents of children with disabilities who are representative of the disability, racial, and ethnic groups in the service area, including, if possible, parents of CCOP participants; (b) representatives of the community mental health, developmental disabilities, alcoholism and drug abuse service providers, representatives of the county department of human services or county social services board, and representatives of school districts and local health departments, at least one of which is a person providing services to children who are eligible for CCOP; and (c) persons in the service area who provide social or educational services to disabled children other than the persons previously specified.

County Responsibilities. Require participating counties to cooperate with the CCOP advisory committee to prepare a program plan, which includes: (a) a description of the proposed program; (b) the estimated number of families to be assessed and served; (c) a list of groups, if any, to be given priority for funding; (d) a description of proposed outreach procedures to ensure that the program will be made available to eligible children; (e) the process that will be used to determine family need; (f) a description of the process for developing and monitoring services plans and for coordinating the provision of services and goods to participating families; (g) a description of the methods that will be used to promote the creation of informal support and advocacy systems for families; and (h) a description of the method that will be used to monitor the program. Require that the proposed plan be submitted to the county board of supervisors in each county in the service area for review and, after being approved by the county boards, the plan be submitted to DHS. Require participating counties, in conjunction with county departments of social services or county social services boards and the administering agency, to coordinate the administration of CCOP with the administration of other publicly-funded programs serving disabled children. Require participating counties to submit all information and reports required by the Department. Specify that private, nonprofit agencies with which DHS contracts to provide CCOP services have the powers and duties of a county department designated to administer the program.

Specify that an agency administering the program: (a) cooperate in the development of the program plan; (b) provide information about the program and other programs for children who have disabilities to families in the service area; (c) implement the program in accordance with the program plan; and (d) designate an employee as the coordinator for each participating family.

Require the county department selected to administer the program to: (a) facilitate assessments by individuals who can determine the needs of the child being assessed and know the availability of services within the county; (b) involve county departments of social services or social service boards, community mental health, developmental disabilities, alcoholism, or drug abuse service providers, health service providers, and the child's family or guardian in assessment activities; (c) ensure the provision of necessary long-term community support services for all eligible children based on DHS standards for purchase of care and services within the limits of state and federal funds; (d) provide for ongoing care management services, periodic case plan review, and follow-up services for any child receiving CCOP services based on DHS standards for the provision of care management within the limits of state and federal funds; (e) determine the fee, if any, for all children eligible for CCOP; (f) serve as or contract with a fiscal agent to perform the responsibilities of enrollees under unemployment insurance law, including remitting any federal unemployment compensation taxes or state unemployment insurance contributions, such as interest and penalties, owed by the child, serving as the representative of the child in any investigation, meeting, hearing, or appeal regarding state unemployment insurance and reserves law or the federal unemployment tax act in which the child is party, and receiving, reviewing, completing, and returning all forms, reports, and other documents required under these provisions of state and federal unemployment law; (g) allow a child to make an informed and voluntary (defined as being according to an individual's free choice, if competent, or by a choice of his or her parent or guardian, if the individual is adjudicated incompetent or is a minor) election to waive the right to a fiscal agent, including any or all of the fiscal agent's responsibilities, and allow this waiver to be rescinded at any time; and (h) develop assessments

and care plans according to uniform criteria established by DHS for children in all long-term care programs.

Specify that, unless an assessment is performed under contract with a managed care organization, the fiscal responsibility of a county for an assessment, case plan, or services provided under CCOP is: (a) the county in which the child has residence (defined as the voluntary occurrence of physical presence with the intent to remain in a fixed place of habitation), if the child is seeking admission to or about to be admitted to an institutional setting, which includes a nursing home, state-operated long-term care facility, or other residential facility that provides care to children outside of a home; (b) the county in which the child is residing if the child is residing in a long-term care facility, unless the child is residing in a state-operated long-term care facility, which includes a State Center for the Developmentally Disabled or a Wisconsin veterans home; (c) the county in which a child's legal residence is established if a child is living in an institutional setting, but has legal residence established in another county, unless the child is residing in a state-operated long-term care facility; and (d) the county in which a child was residing before he or she entered a state-operated long-term care facility or was protectively placed, if the child is residing in a state-operated long-term care facility or is in custody under protective placement.

Funding. Provide funding for CCOP under the long-term care programs appropriation of the DHS budget. Specify that funds may be allocated from this appropriation to each county or private, nonprofit agency with which DHS contracts for the following purposes: (a) to pay assessment and case plan costs not paid by fee, under MA, or through contracts with multi-county consortia, including to reimburse consortia costs related to assessing children eligible for MA due to receipt of certain Social Security aids, Medicare benefits, MA for the medically indigent, and BadgerCare Plus, which would be reimbursed as MA administrative services; and (b) to pay the cost of providing CCOP services not otherwise paid under MA for children who are eligible for MA due to receipt of certain Social Security aids, MA for the medically indigent, or BadgerCare Plus, as long as funds received are spent only in accordance with the child's case plan and service contract.

Specify that no funds could be released without approval by DHS of the county's community options plan, that no county could use funds to pay for services provided to a child who resides in a nursing home, unless this restriction is waived by DHS and funds are provided in accordance with a discharge plan, and that no county may use CCOP funds to purchase land or construct buildings. Specify that receipt of funds by counties must be contingent on county compliance with requirements regarding the distribution of community aids to counties, and that counties may use any excess funds appropriated under the long-term care programs appropriation to pay the cost of providing long-term community support services and for risk reserves. Provide that counties may jointly receive funds if they sign a contract approved by the Secretary of DHS that explains their plans for joint sponsorship. Specify that DHS may require a county to reserve a portion of funds allocated for CCOP to provide services to enrollees whose cost-of-care significantly exceeds the average cost of care of children enrolled in the program if the county demonstrates a pattern of failure to serve such clients.

Authorize DHS to, at the request of a county, carry forward up to five percent of the

amount allocated to the county for a calendar year for use in the next calendar year if up to five percent of the amount allocated has not been spent or encumbered in the current calendar year, except that the amount carried forward would be reduced by the amount the county wishes to place in a risk reserve, and allow DHS to transfer funds within the long-term care appropriation to accomplish this purpose. Provide that the sum carried forward would not affect a county's base allocation, and would lapse to the general fund if not spent in the calendar year to which the funds were carried forward. Prohibit a county from using funds carried forward for administrative or staff costs, unless those costs are associated with implementation of the MA waiver requested to operate CCOP and use of the funds in this manner is approved by DHS. DHS could carry forward funds for a private, nonprofit organization if the organization continues to be eligible to provide services in the subsequent calendar year. Specify that the current policy that allows DHS to carry forward 10 percent of funds for emergencies, justifiable unit service costs above planned levels, and increased costs due to population shifts also applies to private, nonprofit organizations providing CCOP services, and that the amount carried forward would not affect the private, nonprofit organization's base allocation.

Authorize DHS to request a waiver from the U.S. Department of Health and Human Services to allow for the provision of services under the MA program to children who are eligible for CCOP services. Require that reimbursement for services to a county or private, nonprofit agency administering the program be made from the long-term care, federal aid for MA, and community aids and MA payments appropriations, and that payments made for assessment, service, and administrative costs may be used as the state share for the purposes of MA reimbursement. Allow DHS to contract with a county or private, nonprofit agency to provide CCOP services under the MA waiver. Prohibit counties and nonprofit agencies from using funds received under an MA waiver to provide residential services in a group home, defined as any licensed facility operated by a person for the care and maintenance of five to eight children, with more than five beds, unless DHS approves the provision of services in a home with six to eight beds.

Risk Reserve. Specify that a county may place funds allocated for CCOP that are not expended or encumbered in a risk reserve. Specify that the county must notify DHS of the decision and the amount to be placed in the risk reserve. DHS must review and approve or disapprove the terms of the risk reserve escrow account. Provide that if DHS approves the risk escrow account, the county must maintain the risk reserve in an interest-bearing escrow account with a financial institution, and any interest earned on the account must be reinvested in the account. Specify that a county may not expend more than 10 percent of the county's most recent allocation or $750,000, whichever is less, for a risk reserve, and that the total amount of the risk reserve, including interest, may not exceed 15 percent of the county's most recent CCOP allocation. Provide that a county may expend risk reserve funds to pay CCOP expenses, and for administrative or staff costs if approved by DHS. Require counties that maintain risk reserves to annually report the status of the risk reserve, including revenue and disbursements, on a form provided by DHS.

Permit DHS to carry forward to the next fiscal year any funds allocated to counties but not encumbered or carried forward by counties, and to transfer money within the long-term care appropriation to accomplish this purpose. Permit DHS to allocate transferred moneys to counties

during the subsequent fiscal year for the improvement or expansion of long-term community support services for clients whose cost of care significantly exceeds the average cost of care, including to provide the following: (a) specialized training for individuals providing services to CCOP recipients; (b) start-up costs for developing needed services; (c) home modifications; and (d) purchase of medical or other specially adapted equipment. Specify that funds allocated through this process may not be used to replace other state, federal, or county funds provided under any program to a family whose child is receiving services through CCOP.

Family Support Program. Repeal all statutory references to the FSP.

Effective Date. Provide that all of these provisions would take effect January 1, 2016.

Joint Finance/Legislature: Modify the bill to reflect the following changes to CCOP:

a. Specify that children are eligible for the program if they are under 22 years of age and not eligible to receive services in, or be on a waitlist for, an adult long-term care program;

b. Specify under the definition of disability that an individual may be considered disabled if they have a hospital level-of-care, which has resulted or is likely to result in a substantial limitation on the ability to function related to self-care, receptive and expressive language, learning, mobility, and self-direction;

c. Require that the Department consult with programs that provide community-based services to children or families, other publicly funded programs, and social services, mental health, and developmental disabilities programs, including the community aids program, community mental health, developmental disabilities, alcoholism, and drug abuse services, the independent living center program, and the Medical Assistance program (Under the Governor's bill, DHS would be required to consult with "hospitals and other institutional settings".);

d. Specify under duties of participating county departments that a description of the proposed program operations must be included in the program plan;

e. Specify that the program plan shall include a description of the outreach procedures that will be used to ensure that the program will be made available to children with developmental disabilities, rather than children with mental impairments;

f. Require that participating county departments submit the proposed CCOP plan to the Department upon approval by the CCOP advisory committee, rather than approval of the county board of supervisors in each county in the service area; and

g. Specify that the Department may contract with a private, non-profit agency to administer the program, and that the duties of administering agencies apply to a county or agency under contract to provide services under CCOP.

Veto by Governor [E-86]: Delete the word "be" from the definition of child, such that, as vetoed, a child is defined as "a person under 22 years of age who is not eligible to receive

services in or on a waiting list of an adult long-term care program."

[Act 55 Sections: 677, 678, 1535, 1543, 1631, 1632, 1634 thru 1640, 1646, 1793, and 9418(6)]

[Act 55 Vetoed Section: 1535]

3. TRANSFER INDEPENDENT LIVING GRANTS FROM DEPARTMENT OF WORKFORCE DEVELOPMENT [LFB Paper 731]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$68,400	$0	$68,400
FED	597,400	1,200,000	1,797,400
PR	1,200,000	0	1,200,000
Total	$1,865,800	$1,200,000	$3,065,800

Governor: Provide $932,900 ($34,200 GPR, $298,700 FED, and $600,000 PR) annually to reflect the transfer of funding currently budgeted to support independent living centers (ILCs) from the Department of Workforce Development (DWD) to DHS.

Create a PR appropriation that would permit DHS to make grants to ILCs from moneys transferred from a DWD federal program aids appropriation, funded at $600,000 per year, and modify the federal DWD appropriation to require DWD to transfer $600,000 annually to the new PR appropriation in DHS. In addition, provide $298,700 FED annually to reflect that DHS, rather than DWD, would receive federal funds directly to support grants to ILCs. Finally, provide $34,200 GPR annually to DHS, rather than DWD, to serve as the state match for federal grants. Authorize DHS to make grants to independent living centers using PR and FED funds, in addition to its current authority to use GPR funds for this purpose. Repeal a provision that requires DWD to allocate $600,000 in reimbursement received from the federal Social Security Administration for grants to ILCs.

Currently, both DHS and DWD are budgeted funding to support ILCs providing nonresidential services to severely disabled individuals. Under the bill, all grant funding would be budgeted in DHS, which would administer the program.

Joint Finance/Legislature: Increase funding by $600,000 FED annually to correct the amount of federal funds that would be transferred from DWD to DHS under this provision. Specify that DHS make grants for independent living services and independent living centers, in accordance with the purposes for which the funds were received.

[Act 55 Sections: 703h, 714, 716, 743, 744, 1644w, 1645, 1645c, and 1648]

4. DEMENTIA CARE SPECIALISTS [LFB Paper 360]

GPR	$960,000
FED	168,000
Total	$1,128,000

Governor/Legislature: Provide one-time funding of $1,128,000

($960,000 GPR and $168,000 FED) in 2016-17 to support dementia care specialists in aging and disability resource centers (ADRCs).

Dementia care specialists provide cognitive screening and programs that engage individuals with dementia in regular exercise and social activities, promote independence for individuals with dementia, and facilitate the participation of individuals with dementia in research studies to understand the causes of, and explore treatment options for, dementia. They also provide support for family caregivers, including assistance with care planning and connections to support groups. Finally, they provide community support, assisting in the development of dementia-friendly communities through increased civic awareness and dementia-capable emergency response.

DHS awarded one-time funding for dementia care specialists to five ADRCs in calendar year 2013, and to an additional 11 ADRCs in calendar year 2014 to support services through calendar year 2015. ARDCs received $80,000 GPR and $14,000 FED per dementia care specialist. The current dementia care specialists provide services in ADRCs serving 26 counties.

5. PROMISSORY NOTES COUNTED AS ASSETS

GPR	- $300,000
FED	- 450,000
Total	- $750,000

Governor/Legislature: Reduce funding by $250,000 (-$100,000 GPR and -$150,000 FED) in 2015-16 and $500,000 (-$200,000 GPR and -$300,000 FED) in 2016-17 to reflect estimates of savings to MA benefit costs that would result from counting promissory notes as assets in eligibility determinations for MA (in cases where an individual's assets are considered) and MA-supported long-term care programs, including the community options program, community integration programs, community opportunities and recovery program, Family Care, Family Care Partnership, and IRIS.

For these purposes, define a promissory note as a written, unconditional agreement given in return for goods, money loaned, or services rendered under which one party promises to pay another party a specified sum of money at a specified time or on demand. Provide that, when determining or redetermining an individual's financial eligibility for a long-term care program, DHS must include a promissory note as a countable asset if all of the following apply: (a) the individual applying for MA, or his or her spouse, provided the goods, money loaned, or services rendered for the promissory note; (b) the promissory note was entered into on or after the effective date of the bill; and (c) the promissory note is negotiable, assignable, enforceable, and not unmarketable. Specify that a promissory note is presumed negotiable and its asset value is the outstanding principal balance at the time of application for the long-term care program or at the time eligibility for the long-term care program is redetermined, unless the individual shows by credible evidence from a knowledgeable source that the note is nonnegotiable or has a different current value, which will then be considered the asset value.

Provide that the purchase or entering into of a promissory note by an individual or his or her spouse on or after the effective date of the bill is considered a transfer of assets for less than fair market value unless the promissory note's repayment term is actuarially sound, the payments are to be made in equal amounts during the term of the loan with no deferral and no balloon payment, cancellation of the balance upon death of the lender is prohibited, and the promissory

note is negotiable, assignable, enforceable, and does not contain any terms making it unmarketable.

Provide that the value of a promissory note purchased before the effective date of the bill that does not satisfy requirements (a) through (c) above is the outstanding balance due on the date that the individual applies for MA for nursing facility or other long-term care services. Specify that the value of a promissory note purchased or entered into on or after the effective date of the bill that does not satisfy requirements (a) through (c) above is the outstanding balance on the date that the individual applies for MA for nursing facility or other long-term care services, or on the date that the individual's eligibility is redetermined.

Under current law, institutionalized individuals and noninstitutionalized individuals participating in long-term care programs must meet certain asset requirements to qualify for MA. Individuals participating in long-term care programs are not eligible for MA-funded long-term care services if they transfer certain property at less than fair market value, either while they are receiving MA-funded services or within 60 months before the first day that they were both eligible for MA and receiving MA-funded long-term care services. Such a transfer is considered divestment. With limited exceptions, individuals engaging in divestment are not eligible for MA services for a divestment penalty period, which is equal to the number of days of private pay nursing home care that could have been paid for with the amount of resources that were divested.

[Act 55 Sections: 1621 and 1803 thru 1806]

6. CHILDREN'S LONG-TERM CARE SERVICES [LFB Paper 361]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$0	$752,100	$752,100
FED	0	1,047,100	1,047,100
Total	$0	$1,799,200	$1,799,200

Governor: Require DHS to deposit any funds the state retains for federal MA claims for school-based health care services that exceed $42,200,000 in 2015-16, and $41,700,000 in 2016-17 and each fiscal year thereafter to the MA trust fund. Provide that all of these excess funds would be credited to a current SEG appropriation, which DHS would use to fund reductions in waiting lists for children's long-term care services and other programs benefiting children.

Currently, the state claims federal MA matching funds for eligible school-based health care services that schools provide to children enrolled in the MA program. Of the federal MA matching funds the state receives, 60% is forwarded to the schools, and 40% is retained by the state and deposited to the general fund. As the administration estimates that $42,200,000 in 2015-16 and $41,700,000 in 2016-17 will be deposited to the general fund from this source, it is not assumed that any additional funding would be provided to support children's long-term care support services and other programs benefitting children. However, under this provision, should the state's share of these MA revenues exceed these statutory amounts, the excess funding would

be allocated to reduce waiting lists for children's long-term care services and other programs benefitting children, rather than be deposited to the state's general fund.

The children's long-term support (CLTS) waiver program provides MA-funded, community-based supports and services to physically and developmentally disabled children, including children with autism, and children with severe emotional disturbance. As of December, 2014, approximately 5,600 children were enrolled in the CLTS waiver program and approximately 2,200 children were on waiting lists for long-term care services.

Joint Finance/Legislature: Include provision. In addition, provide $886,300 ($370,100 GPR and $516,200 FED) in 2015-16 and $912,900 ($382,000 GPR and $530,900 FED) in 2016-17 to fund services to approximately 50 children on the CLTS and autism services waitlists, beginning in 2015-16.

[Act 55 Sections: 690, 1030, and 1800]

7. MA REIMBURSEMENT FOR NURSING HOMES [LFB Paper 362]

GPR	$3,186,300
FED	4,431,100
Total	$7,617,400

Joint Finance/Legislature: Provide $7,617,400 ($3,186,300 GPR and $4,431,100 FED) in 2016-17 to fund a 1% acuity increase for nursing homes, beginning in 2016-17.

Additionally, direct the Department to study the labor region methodology, and to submit a report to the Legislature that proposes changes to the labor region methodology, as necessary, such that any proposed labor region methodology results in adjustments to direct care costs that reflect labor costs for nursing homes in each county no later than July 1, 2016. Prohibit DHS from implementing any proposed changes without enactment of authorizing legislation.

Veto by Governor [E-74]: Delete provision that would require DHS to study the labor region methodology, and to submit a report to the Legislature that proposes changes to the methodology.

[Act 55 Vetoed Section: 9118(4u)]

8. EXEMPT INSTITUTIONS FOR MENTAL DISEASE AND STATE-ONLY LICENSED NURSING HOMES FROM BED ASSESSMENT

	Jt. Finance/Leg. (Chg. to Base)	Veto (Chg. to Leg)	Net Change
SEG-REV	- $640,600	$640,600	$0
GPR	$640,600	- $640,600	$0
SEG	- 640,600	0	- 640,600
Total	$0	- $640,600	- $640,600

Joint Finance/Legislature: Exempt county government-owned institutions for mental disease (IMDs) and facilities that are state-licensed but not certified to participate in the Medicaid or Medicare programs from the nursing home bed assessment, unless CMS determines that exempting these facilities would not be permissible under federal statutes or rules relating to state health care provider assessments.

Reduce estimates of segregated revenue to the MA trust fund for MA benefits by $320,300 annually. Reduce MA SEG benefits funding by $320,300 annually and increase GPR funding for MA benefits by a corresponding amount to reflect the estimated fiscal effect of exempting these facilities from the nursing home bed assessment.

Veto by Governor [E-80]: Delete provision. In addition, the Governor's partial veto intended to reduce GPR funding to support MA benefits by $320,300 annually to reflect the deletion of this provision. However, the veto instead reduced GPR funding that supports the general program operations of health services facilities for mental health and developmental disabilities by $320,300 annually.

[Act 55 Vetoed Sections: 481 (as it relates to appropriations under s. 20.435(2)(a)), and 1875d thru 1875f]

9. COUNTY-TO-COUNTY NURSING HOME BED TRANSFERS

Joint Finance/Legislature: Require DHS to develop a policy that specifies the procedures for applying for, and receiving approval of, the transfer of available, licensed nursing home beds among counties. Require the Department to report to the Joint Committee on Finance no later than July 1, 2016.

Veto by Governor [E-79]: Delete provision.

[Act 55 Vetoed Section: 9118(7g)]

10. HEALTHY AGING GRANTS

GPR	$400,000

Joint Finance/Legislature: Provide $200,000 in one-time funding each year of the 2015-17 biennium for a grant to a private, non-profit entity that will use these funds to conduct the following activities: (a) coordinate the implementation of evidence-based health promotion programs in healthy aging; (b) coordinate with academic and research institutes regarding research on healthy aging; (c) serve as a statewide clearinghouse on evidence-based disease prevention and health promotion programs; (d) provide training and technical assistance to the staff of county departments, administering agencies, and other providers of services to aging populations; (e) collect and disseminate information on disease prevention and health promotion in healthy aging; (f) coordinate public awareness activities related to disease prevention and health promotion in aging; and (g) advise the Department on public policy issues concerning disease prevention and health promotion in aging. Create an annual GPR appropriation, entitled "Healthy aging; evidence-based training and prevention" among the Department's programs for

disability and elder services and repeal the appropriation on July 1, 2017.

Veto by Governor [E-82]: Delete the requirement that the funds be granted to a private, non-profit entity. In addition, delete the requirements listed under (a) through (g) above, which specify the activities that the grant recipient must conduct.

[Act 55 Sections: 703r, 703s, 9118(4f), and 9418(8f)]

[Act 55 Vetoed Sections: 703r and 9118(4f)]

11. PROVISION OF ADDITIONAL NURSING HOME BEDS

Joint Finance/Legislature: Require the Department of Health Services to redistribute three nursing home beds that are currently available under the statewide bed limit to a facility that meets all of the following criteria: (a) has a licensed bed capacity of no more than 75, on the effective date of the bill; (b) is covered by a continuing care permit under s. 647.02 of the statutes, on the effective date of the bill; (c) is located in a county with a population of at least 380,000 and adjacent to a county with a population of at least 750,000, on the effective date of the bill; and (d) for which the facility has applied for the beds using an application that, on a form provided by the Department, includes the applicant's per diem operating and capital rates. The only facility in the state that meets criteria (a) through (c) is Tudor Oaks Health Center in Muskego, WI.

[Act 55 Section: 9118(3g)]

Medical Assistance -- Administration

1. CREATE THE DIVISION OF MEDICAID SERVICES [LFB Paper 365]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
GPR	$0	6.89	$0	0.00	$0	6.89
FED	- 588,400	- 6.89	- 233,000	- 1.00	- 821,400	- 7.89
Total	- $588,400	0.00	- $233,000	- 1.00	- $821,400	- 1.00

Governor: Reduce funding by $588,400 (-$297,200 GPR and -$291,200 FED) in 2015-16 and increase funding by $297,200 GPR and decrease funding by $297,200 FED in 2016-17 to reflect the net effect of consolidating the Division of Health Care Access and Accountability (DHCAA) with MA-funded long-term care programs administered by the Division of Long-Term Care (DLTC) to create a new Division of Medicaid Services (DMS). Beginning in 2015-16, convert 6.89 FED positions, which are currently supported by the Social Services Block Grant, to GPR positions for the general program operations of DMS.

Rename and renumber appropriations formerly under DHCAA and DLTC to reflect the inclusion of long-term care services in DMS appropriations. Modify statutory references to reflect appropriations that would be created, repealed, and modified in the bill.

Require DHS to submit to the State Budget Office in the Department of Administration a report on the final organization of DMS before March 31, 2016. Transfer the unencumbered balances of all appropriations that would be repealed to corresponding appropriations in DMS on the effective date of the bill. All balances encumbered by DLTC would be settled out of the appropriations under DLTC. Under the bill, all positions formerly budgeted in DLTC would be transferred to DMS. Consequently, DLTC would not be replaced by another division with fewer staff or administrative responsibilities.

Joint Finance/Legislature: Adopt the Governor's recommendations. In addition, delete 1.00 FED unclassified division administrator position, beginning in 2015-16, which was retained by DHS when the Department of Children and Families was created, but has remained vacant since 2011. Reduce funding by $116,500 FED annually to reflect the elimination of this position. Additionally, delete 1.00 GPR unclassified division administrator position as of June 30, 2017, which currently serves as the Administrator of the Division of Long-Term Care. Reduce by one the statutory number of unclassified positions in DHS on the bill's effective date, and reduce by one the statutory number of unclassified positions in DHS, effective June 30, 2017.

The following table identifies the funding and position transfers enacted in Act 55.

Veto by Governor [E-87]: Modify the bill to delete provisions that eliminate 1.00 FED unclassified position on the effective date of the bill, and 1.00 GPR unclassified position as of June 30, 2017.

[Act 55 Sections: 12, 674 thru 676, 682 thru 685, 688, 695, 696, 698 thru 700, 703b thru 713, 715, 717 thru 719, 1028, 1525 thru 1527, 1529 thru 1532, 1534, 1542, 1568, 1586, 1603, 1626, 1630, 1647, 1794, 1814, 1844, 1888, 1892, 9118(10), and 9218(1)]

[Act 55 Vetoed Sections: 3665r, 3665s, and 9418(7p)]

Transfer of Funding and Positions to Create the Division of Medicaid Services

	Funding						Positions Beginning in 2015-16		
	2015-16			2016-17					
	GPR	FED	PR	GPR	FED	PR	GPR	FED	PR
Division of Medicaid Services (Formerly DHCAA)									
Contracted Services for MA, FoodShare, Resource Centers, and Other Entities Performing Resource Center Functions	$5,895,300	$8,513,700		$6,441,300	$8,243,200				
Administration -- Federal Program Operations		5,666,900			5,666,900			55.99	
Federal Program Operations -- Aging Programs		1,942,600			1,942,600			15.74	
Federal Projects Operations		4,214,400			4,214,400			9.39	
Interagency and Intra-Agency Aids			$1,783,300			$1,783,300			15.24
Administrative Services Supported by Fees			30,000			30,000			
Recovery of Costs -- Birth-to-3 Program			84,300			84,300			
Audits and Investigations Supported by Provider Assessments			19,200			19,200			0.20
Gifts and Grants; Health Care Financing			276,100			270,100			
Interpreter Services for the Hearing Impaired Supported by Fees			39,900			39,900			
Disabled Children's Support Waiver Supported by Fees, Collections and Recoveries			1,567,100			1,567,300			
County Contributions for Family Care, Birth-to-3 and the Children's Long-Term Support Program			42,904,200			42,749,000			
Third Party Administrator for Children's Long-Term Care Programs			12,165,500			12,165,500			
Community Options Programs and Long-Term Care Support Pilot Programs	24,982,000			20,443,300					
Community Options Programs and Family Care Management Organizations	59,083,400			59,877,900					
General Program Operations	9,281,200			9,281,100			62.39		
Programs for Disability and Elder Services (Formerly DLTC)									
Social Services Block Grant -- Local Assistance		1,326,600			1,258,600				
MA -- State Administration		-14,180,600			-13,910,100			-55.99	
Federal Program Operations -- Aging Programs		-1,942,600			-1,942,600			-15.74	
Social Services Block Grant -- Aids to Individuals and Organizations		-873,700			-811,700				
Social Services Block Grant -- Operations		-744,100			-744,100			-6.89	
Federal Project Operations		-4,214,400			-4,214,400			-9.39	
Interagency and Intra-Agency Programs			-1,783,300			-1,783,300			-15.24
Fees for Administrative Services			-30,000			-30,000			
Recovery of Costs for Long-Term Care Programs			-84,300			-84,300			
Gifts and Grants -- Long-Term Care			-276,100			-270,100			
Interpreter Services for the Hearing Impaired Supported by Fees			-39,900			-39,900			
Third Party Administrator for Children's Long-Term Care Programs			-12,165,500			-12,165,500			
Disabled Children's Support Waiver Supported by Fees, Collections and Recoveries			-1,567,100			-1,567,300			
Regulation of Health Services Supported by Application Fees under Chapter 150			-19,200			-19,200			-0.20
County Contributions for Family Care, Birth-to-3 and the Children's Long-Term Support Program			-42,904,200			-42,749,000			
Community Options Programs and Long-Term Care Support Pilot Programs	-24,982,000			-20,443,300					
Community Options Programs and Family Care Management Organizations	-59,083,400			-59,877,900					
Community Aids	-1,326,600			-1,258,600					
Community Aids -- Family Care Resource Centers	235,300			761,700					
General Program Operations	-14,382,400			-14,928,300			-55.50		
Net Fiscal Effect	**-$297,200**	**-$291,200**	**$0**	**$297,200**	**-$297,200**	**$0**	**6.89**	**-6.89**	**0.00**

2. FOODSHARE EMPLOYMENT AND TRAINING (FSET) PROGRAM [LFB Paper 366]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$18,110,900	- $18,597,500	- $486,600
FED	18,915,600	2,633,000	21,548,600
Total	$37,026,500	- $15,964,500	$21,062,000

Governor: Provide $7,070,500 ($1,139,200 GPR and $5,931,300 FED) in 2015-16 and $29,956,000 ($16,971,700 GPR and $12,984,300 FED) in 2016-17 to fund the annualized costs of providing FoodShare employment and training (FSET) services to certain able-bodied adults without dependent children (ABAWDs), who may seek these services as one way of fulfilling work requirements enacted under 2013 Act 20. Under these requirements, ABAWDs are limited to three months of FoodShare benefits unless they work an average of 20 hours per week, participate in and comply with the requirements of a work program for 20 hours per week, or spend 20 hours per week in any combination of work and participation in a work program. The work requirements were implemented in Kenosha, Racine, and Walworth Counties in July, 2014, and the remaining counties in April, 2015. FSET services are also available to other adult FoodShare recipients who wish to participate in the program.

FSET is intended to provide education, skills, and work experience to enable FoodShare recipients, including ABAWDs, to obtain competitive employment and enhance earning potential. The program is supported with: (a) a $1.5 million annual FED allocation that requires no state match for services that enable individuals to obtain unsubsidized employment; (b) FED funds that match state and local funds for administrative expenses that exceed the 100% federal allocation and for expenses directly related to supportive services to participating individuals; (c) GPR base funding for FSET service costs; and (d) county contributions.

Under Act 20, the amount of state and federal funding budgeted for FSET services for ABAWDs in 2014-15 ($22,958,400 all funds) was based on the assumption that the work requirements would take effect in Kenosha, Racine, and Walworth counties in July, 2014, three other regions by October, 2014, and the rest of the state by January, 2015. Consequently, the agency's base funding for FSET services for ABAWDs does not reflect the annualized, statewide costs of these services.

There are two sources of federal funding for FSET: (a) $1.5 million annually, with no match requirement; and (b) funds that match state and county funds for eligible administration and service costs. Although it is anticipated that both FED sources would support FSET services for non-exempt ABAWDs and voluntary FSET participants, the table allocates the $1.5 million exclusively for FSET services for voluntary participants. The bill would also provide $1,555,000 GPR annually for DHS to provide to FSET vendors to retain or attract local funding, which DHS refers to as "incentive bonuses."

Joint Finance/Legislature: Modify the Governor's recommendation by increasing funding by $31,800 (-$1,625,800 GPR and $1,657,600 FED) in 2015-16 and by $376,600

(-$598,800 GPR and $975,400 FED) in 2016-17 to reflect the following program cost estimates.

FSET Expenditures by Funding Source and Year
Act 55

	GPR	County	FED	Total
2015-16				
FSET Services				
Non-Exempt ABAWDs	$17,588,700	$1,423,700	$23,625,400	$42,637,800
Voluntary Participants	3,413,700	276,300	3,477,000	7,167,000
Subtotal -- Services	$21,002,400	$1,700,000	$27,102,400	$49,804,800
FSET Administration				
DHS Program Management	$250,000	$0	$250,000	$500,000
Program Evaluation	125,000	0	125,000	250,000
Incentive Bonus	1,550,000	0	1,550,000	3,100,000
Subtotal -- Administration	$1,925,000	$0	$1,925,000	$3,850,000
GPR Carryover from Previous Year	-$9,488,662	$0	$0	-$9,488,662
Base Funding	-13,925,300	-1,700,000	-21,438,500	-37,063,800
Change to Base	-$486,600	$0	$7,588,900	$7,102,300
2016-17				
FSET Services				
Non-Exempt ABAWDs	$24,580,600	$1,481,900	$29,026,300	$55,088,800
Voluntary Participants	3,617,600	218,100	4,271,900	8,107,600
Subtotal -- Services	$28,198,200	$1,700,000	$33,298,200	$63,196,400
FSET Administration				
DHS Program Management	$250,000	$0	$250,000	$500,000
Program Evaluation	300,000	0	300,000	600,000
Incentive Bonus	1,550,000	0	1,550,000	3,100,000
Subtotal -- Administration	$2,100,000	$0	$2,100,000	$4,200,000
GPR Carryover from Previous Year	$0	$0	$0	$0
Base Funding	-13,925,300	-1,700,000	-21,438,500	-37,063,800
Change to Base	$16,372,900	$0	$13,959,700	$30,332,600

In addition, due to uncertainty regarding future program costs, transfer $16,372,900 GPR, the amount of the net funding increase in 2016-17, to the Joint Committee on Finance program supplements appropriation. DHS could seek the release of these funds under s. 13.10 to support FSET program costs in 2016-17. See "Program Supplements."

3. MA AND FOODSHARE ADMINISTRATION CONTRACTS [LFB Paper 367]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$11,111,500	- $2,058,500	$9,053,000
FED	9,090,600	- 3,532,900	5,557,700
PR	0	- 121,600	- 121,600
Total	$20,202,100	- $5,713,000	$14,489,100

Governor: Provide $9,454,100 ($4,703,300 GPR and $4,750,800 FED) in 2015-16 and $10,748,000 ($6,408,200 GPR and $4,339,800 FED) in 2016-17 to fund the difference between the estimated cost of contracted services for the administration of the state's MA and FoodShare programs in each year of the 2015-17 biennium and base funding for these contracts. This item does not include funding changes for contracts with income maintenance consortia, which perform eligibility determination and case management functions for these programs, or funding changes for state staff that perform program management functions.

Fiscal Agent Contract (HP). The fiscal agent for the MA program, currently HP Enterprise Services, processes provider claims and provides member and provider enrollment services, provides customer service for members and providers, produces summary reports, conducts program integrity functions, and maintains the Medicaid Management Information System (MMIS). The bill would provide additional funding to support higher costs for a newly-renegotiated five-year contract, including: (a) a higher "flat fee" component of the contract; (b) increased funding to support projects that are expected to reduce benefits costs and meet federal requirements and other program objectives; (c) inflationary increases incorporated in the contract; and (d) continuation of projects to implement provisions of the federal Affordable Care Act.

CARES (Deloitte). The Client Assistance for Re-employment and Economic Support (CARES) system assists state and county staff in determining applicants' eligibility for MA, SeniorCare, FoodShare, Wisconsin Shares, and TANF/W-2. DHS contracts with Deloitte for programming, analysis and maintenance tasks for CARES. The bill would provide additional funding to increase the number of budgeted hours of services Deloitte will provide, from approximately 189,600 hours budgeted in 2014-15 under 2013 Act 20, to 234,000 hours in each year of the 2015-17 biennium to support current operations, maintenance and reporting requirements, new projects to meet federal requirements, and to implement state initiated program changes. In 2014-15, DHS expects to purchase approximately 270,600 hours of services from Deloitte. The estimate also reflects a provision in the current contract that increases the hourly rate DHS pays for these services, from $104 to $109 per hour, beginning in 2016, and $115 per hour, beginning in 2017. In addition, it is anticipated that a greater portion of these services will be for maintenance, rather than development services (for which greater federal cost-sharing is available), resulting in an increase in GPR and a corresponding reduction of FED needed to support the contract.

Minor funding changes are requested for other CARES-related costs, including hosting and data storage charges DHS pays to the Department of Administration's Division of Enterprise

Technology.

Other Contracts (Various Entities). DHS contracts with several other entities to provide administrative services to the MA program, including rate-setting for hospitals, actuarial services, assistance in claiming federal funds for MA-eligible school-based medical services and services provided by counties, and consulting services. The bill would make minor funding changes for these contracts.

Base funding for these contracts is $142,870,000 ($48,816,200 GPR and $94,053,800 FED).

Division of Long-Term Care Contracts. The Division of Long-Term Care funds contracted services for MA long-term care programs as part of the Division's general program operations budget. These services include CARES, allocated costs from the fiscal agent contract, actuarial services, nursing home rate-setting, quality review, and external advocacy services. The bill would provide $724,900 ($674,900 GPR and $50,000 FED) in 2015-16 and $1,000,300 ($1,220,800 GPR and -$220,500 FED) in 2016-17 to increase funding for contracted services.

Joint Finance/Legislature: Modify the bill as follows: (a) reduce funding by $720,000 (-$280,800 GPR and -$439,200 FED) annually to reduce by 10% the amount of funding budgeted for the state's fiscal agent to conduct planned projects; (b) reduce funding by $340,000 (-$170,000 GPR and -$170,000 FED) in 2016-17 to fund the contract for the enrollment broker in 2016-17 at the same level as 2015-16 ($2,000,000 annually); and (c) reduce funding by $1,917,000 (-$644,600 GPR, -$60,800 PR and -$1,211,600 FED) in 2015-16 and by $2,016,000 (-$682,300 GPR -$60,800 PR and -$1,272,900 FED) in 2016-17 to fund 216,000 hours of contracted work for CARES modifications per year, a 20% increase from the number of contracted hours budgeted in the 2015-17 biennium (180,000 hours), rather than a 30% increase (234,000 hours per year), as recommended by the Governor. In addition, transfer $530,600 GPR and $2,737,900 FED annually from a general program operations appropriations to the appropriations that fund contracted services to consolidate funding for contracts in these appropriations.

4. INCOME MAINTENANCE CONSORTIA FUNDING ALLOCATIONS [LFB Paper 368]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
GPR	- $4,401,500	0.00	- $6,518,000	- 9.10	- $10,919,500	- 9.10
FED	24,317,400	0.00	- 3,511,100	- 8.40	20,806,300	- 8.40
Total	$19,915,900	0.00	- $10,029,100	- 17.50	$9,886,800	- 17.50

Governor: Provide $10,836,600 (-$3,021,600 GPR and $13,858,200 FED) in 2015-16 and $9,079,300 (-$1,379,900 GPR and $10,459,200 FED) in 2016-17 to support services performed by IM consortia and tribes for the administration of the MA and FoodShare programs. The funding changes reflect several factors.

First, DHS would maintain base contract funding amounts for consortia and tribes ($27,883,800 all funds) through calendar year (CY) 2017. However, the funding in the bill reflects the administration's assumption that the state will claim and receive enhanced federal matching funds for base allocations and supplemental funds for IM consortia to implement the federal Affordable Care Act (ACA), equal to approximately 60% of costs, rather than the regular 50% rate applicable to these functions, through CY 2015. Under the ACA, states may receive enhanced federal matching funds to support 75% of the cost of certain eligibility work. Based on workload and time reporting, the administration estimated that the resulting "blended" matching rate for IM functions would be 60% through CY 2015.

Second, beginning in CY 2016, DHS would reduce supplemental funding the agency provided to IM consortia budgeted in 2013 Wisconsin Act 20 (the 2013-15 biennial budget act) to meet workload relating to additional responsibilities for IM agencies to implement the ACA, including anticipated increases in BadgerCare Plus enrollment, from $9,814,800 (all funds) in CY 2015 to $4,907,400 (all funds) in CY 2016 to $2,453,700 (all funds) in CY 2017. However, no base funding for the supplement would be deleted from the DHS budget. Instead, the GPR and FED savings resulting from the phase down of the ACA supplemental funds would be placed in unallotted reserve ($1,192,200 GPR and $1,174,500 FED in 2015-16 and $3,069,100 GPR and $3,069,100 FED in 2016-17).

Third, the bill would maintain annual supplemental funding ($4,730,100 all funds) through CY 2017 to support workload relating to work requirements for FoodShare recipients who are able-bodied adults without dependent children (ABAWDs).

Finally, the funding change under this item reflects a change in the allocation of state fiscal year funds to support county IM consortia calendar year allocations. Under Act 20, DHS was budgeted funding to enable it to pay three months of calendar year IM expenses in the first half of the calendar year and the remaining nine months of calendar year IM expenses in the second half of the calendar year (from the next fiscal year's appropriation), creating a one-time savings in state funds. The funding in the Governor's 2015-17 biennial budget bill would enable DHS to return to the previous practice of paying IM consortia 50% of the state fiscal year funding in the first half of one calendar year and 50% of the next fiscal year funding in the second half of the same calendar year.

The following table summarizes actual 2014 (all funds) IM allocations to the consortia and tribes and CY 2015, 2016, and 2017 allocations under the Governor's budget recommendations.

Budgeted Calendar Year Income Maintenance Allocations (All Funds)*
Governor's Recommendations

	Actual	Governor's Recommendations		
	2014	2015	2016	2017
Base Allocation	$27,674,500	$27,883,800	$27,883,800	$27,883,800
Affordable Care Act Supplement	18,060,000	9,814,800	4,907,400	2,453,700
FoodShare Work Requirement Supplement	725,500	4,730,100	4,730,100	4,730,100
Total	$46,460,000	$42,428,700	$37,521,300	$35,067,600

*Excludes county-funded costs and federal match the state claims for county-funded costs and potential increases to the ACA supplement from moneys budgeted in unallotted reserve.

Joint Finance/Legislature: Modify the bill as follows.

ACA Supplemental Funding. Reduce funding budgeted in DHS for income maintenance consortia and tribes to meet workload relating to the federal Affordable Care Act by $1,716,000 (-$1,755,000 GPR and $39,000 FED) in 2015-16 and by $3,070,100 ($8,800 GPR and -$3,078,900 FED) in 2016-17 to reflect reestimates of funding needed for this purpose, including the assumption that enhanced funding would be available for costs through calendar year 2016, and the deletion of federal funding budgeted in unallotted reserve. In addition, transfer funding the Governor recommended be provided in unallotted reserve ($1,192,200 GPR in 2015-16 and $3,069,100 GPR in 2016-17) to the Joint Committee on Finance program supplements appropriation. DHS could seek the release of this funding, using the procedures under s. 13.10 of the statutes, to supplement funding allocations to IM consortia and tribes if DHS determines there is a need to supplement budgeted IM allocations to meet ACA-related workload costs. See "Program Supplements."

FoodShare Work Requirement Supplement. Modify the bill to budget all GPR funding for the FoodShare work requirement supplement for 2016-17 ($2,365,000) in one-time funding so that it would be removed as a standard budget adjustment as part of the 2017-19 budget.

MilES Staff and Funding. Delete 17.5 positions (-9.10 GPR positions and -8.40 FED positions) in MilES, beginning in 2016-17, to reduce by 25% the number of additional positions provided in 2013 Act 20 (the 2013-15 budget act) for DHS to meet workload relating to the ACA and BadgerCare Plus eligibility requirements. Reduce funding in the bill by $981,700 (-$510,500 GPR and -$471,200 FED) in 2016-17 to delete base funding budgeted for these positions.

5. FUNERAL AND CEMETERY AIDS [LFB Paper 369]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR-REV	$242,000	$168,000	$410,000
GPR	$327,400	- $1,399,400	- $1,072,000
FED	242,000	0	242,000
PR	- 410,000	0	- 410,000
Total	$159,400	- $1,399,400	- $1,240,000

Governor: Provide $20,800 GPR in 2015-16 and $138,600 ($306,600 GPR, $242,000 FED, and -$410,000 PR) in 2016-17 and increase estimated revenue to the general fund by $242,000 in 2016-17 to reflect the following items relating to the Wisconsin funeral and cemetery aids program (WFCAP).

Cost-to-Continue Reestimate. Provide $382,900 GPR in 2015-16 and $862,600 GPR in 2016-17 to fund projected increases in the cost of reimbursing funeral homes, cemeteries, and crematories for eligible expenses, based on current law.

Coverage of Reimbursable Expenses under Life Insurance Policies. Provide that, if a recipient, the recipient's spouse, or another person owns a life insurance policy insuring the recipient's life and the face value of the policy is more than $3,000, any amount that DHS is obligated to pay under WFCAP would be reduced by one dollar for every dollar by which the face value of the policy exceeds $3,000. Reduce funding by $362,100 GPR in 2015-16 and by $724,100 GPR in 2016-17 to reflect estimates of the reduction in reimbursable costs that would result from this change.

Recovery of Funeral and Cemetery Aids Payments from the Decedent's Estate and Estate of Surviving Spouse. Require DHS to pursue recovery of WFCAP payments provided on behalf of a decedent by making a claim in the decedent's estate and the estate of the decedent's surviving spouse. For this purpose: (a) modify the current statutory definition of a "nonclient surviving spouse" under the estate recovery statutes as any person who was married to a client while the client was receiving or when the client received services or aid for which the costs may be recovered and who survived the client; and (b) modify the current definition of a "nonrecipient surviving spouse" to be any person who was married to a recipient while the recipient was receiving or when the recipient received public assistance and who survived the recipient.

However, unlike other benefits for which DHS pursues recoveries, DHS would pursue recoveries for funeral and cemetery aids benefits even if the decedent on whose estate the claim is made has a surviving spouse or a surviving child who is under the age of 21 or disabled. Further, DHS could not waive recovery of funeral and cemetery benefits if the agency determined that recovering the amount paid on the decedent's behalf would constitute an undue hardship.

Increase estimated revenue to the general fund by $242,000 in 2016-17 to reflect the

administration's estimates of amounts that would be recovered under this provision. However, almost all amounts recovered under WFCAP would reduce amounts that would otherwise be recovered under the MA estate recovery program. Consequently, increase funding for MA benefits by $168,100 GPR and $242,000 FED in 2016-17 to replace funding that would otherwise be available from these recoveries. Reduce MA benefits funding supported by MA recoveries by $410,000 PR in 2016-17.

Provide that all the statutory changes would first apply to individuals receiving funeral and cemetery aids benefits who die on the bill's general effective date.

Joint Finance/Legislature: Modify the bill as follows.

Cost-to-Continue Funding. Reduce funding budgeted in DHS for WFCAP by $970,700 GPR in 2015-16 and $428,700 GPR in 2016-17 to reflect a reestimate of the amount of funding that will be needed to support program costs in the 2015-17 biennium. However, rather than delete this funding from the bill, budget this amount of funding in the Joint Finance Committee's program supplements appropriation. Should the amounts budgeted for the program in DHS be insufficient to fully fund program costs, DHS could seek the release of some or all of this funding from the Committee under procedures specified under s. 13.10 of the statutes. See "Program Supplements."

Recovery of WFCAP Payments. Adopt the Governor's recommendations, but increase estimates of GPR revenues that would be received due to the estate recovery provisions by $168,000 in 2016-17. In addition, incorporate the following changes to reflect the administration's intent. First, revise the definition of a "nonclient surviving spouse" under the estate recovery statutes to mean either: (a) a person who was married to a client when the client was receiving or received services or aid for which the costs may be recovered and who survived the client; or (b) a person who was married to a client on whose behalf funeral, burial, or cemetery expenses aid was paid, who was married to the client at the client's death, or when the client was receiving or received any of the WFCAP benefits that made the client an eligible recipient under that program, or at both times, and survived the client. Second, correct a reference to permit DHS to pursue recoveries of non-probate property and estates that are administered by transfer of affidavit, in addition to filing claims in estates that are administered under court supervision. Finally, correct a reference to clarify that current hardship exceptions would apply to the Wisconsin chronic disease program, but not for recoveries under the WFCAP program.

Assessment of County Fees to Funeral Homes, Cemeteries and Crematories. Provide that a funeral home, cemetery or crematory is not required to pay the following fees in cases where the funeral home, cemetery or crematory requests and receives reimbursement under WFCAP: (a) fees for services rendered by a coroner; (b) fees assessed for the signing of a death certificate by a coroner or medical examiner; or (c) fees assessed by a county related to transportation services. Specify that this provision would first apply to individuals who die on and after September 1, 2015, for whom reimbursement under WFCAP is provided.

In addition, prohibit a county from increasing any of the fees described under (a), (b) and (c) above, effective retroactively to April 17, 2015, until two years after the bill's general

effective date. Provide that after this period is ended, counties may increase these fees by no more than the increase in the consumer price index for the previous calendar year.

[Act 55 Sections: 1817 thru 1827, 1831 thru 1832, 1834b, 1834c thru 1843, 1845, 1909s, 4588, 4595, 4623 thru 4630, 9318(1), and 9318(3j)]

6. FEDERAL MATCH FOR BOARD ON AGING AND LONG-TERM CARE OMBUDSMAN POSITIONS [LFB Paper 358]

FED	$82,500

Governor/Legislature: Provide $82,500 in 2016-17 to reflect additional federal MA administrative funding the state would claim for ombudsman services provided by the Board on Aging and Long-Term Care (BOALTC). The bill would provide BOALTC 3.0 additional ombudsman specialist positions, beginning in 2016-17, as part of the administration's proposed changes in the state's long-term care programs (see "Board on Aging and Long-Term Care"). These federal MA funds would be transferred to a program revenue appropriation for BOALTC to partially support the costs of these additional positions.

7. FOODSHARE EMPLOYMENT AND TRAINING (FSET) DRUG TESTING [LFB Paper 370]

Governor: Require DHS to request a waiver from the U.S. Department of Agriculture (USDA) to screen FoodShare employment and training (FSET) program participants for illegal use of controlled substances without a valid prescription, and, if indicated, test, as specified by DHS in the waiver request, FSET participants for illegal use of controlled substances without presenting evidence of a valid prescription. If such a waiver is granted and in effect, require DHS to screen and, if indicated, test FSET participants in accordance with the waiver granted by the USDA. Require DHS to include in its 2017-19 budget request an estimate of the future fiscal effect of the program, if a waiver is approved by the USDA during the 2015-17 biennium.

The bill is unclear as to whether the Department would have the authority to request a waiver to institute consequences associated with a positive test result, or what the consequences, if any, would be if one tests positive for a drug test.

Joint Finance/Legislature: Delete provision.

Instead, require DHS to promulgate rules to develop and implement a drug screening, testing, and treatment policy for FSET participants who are able-bodied adults without dependent children and subject to the FoodShare work requirements. Specify that the program would include at least the following elements:

a. Only participants for whom there is reasonable suspicion of use of a controlled substance without a valid prescription may be subject to testing. The policy must include mechanisms for the determination of a reasonable suspicion to require submission to a drug test.

b. If a participant tests negative, or tests positive for the use of a controlled substance but presents evidence satisfactory to DHS that the individual possesses a valid prescription for each

controlled substance for which the individual tests positive, the individual will have satisfactorily completed the substance abuse testing requirements.

c. If a participant tests positive for use of a controlled substance for which he or she does not have a valid prescription, then the individual must participate in state-sponsored substance abuse treatment to remain eligible for FSET.

d. While participating in state-sponsored treatment, an individual who has tested positive for the use of a controlled substance without a valid prescription for the controlled substance must submit to random testing for the use of a controlled substance, and the test results must be negative, or positive with evidence of a valid prescription, in order for the individual to remain eligible for FSET.

e. If a test result of an FSET participant enrolled in state-sponsored treatment is positive and the individual does not have a valid prescription for the controlled substance for which the individual tests positive, the individual may begin treatment again one time and will remain eligible for FSET.

f. If an individual completes treatment and tests negative for use of a controlled substance, or tests positive for the use of a controlled substance but presents evidence satisfactory to DHS that the individual possesses a valid prescription for each controlled substance for which the individual tests positive, the individual will have satisfactorily completed the substance abuse screening and testing requirements.

Create a biennial GPR appropriation that would authorize DHS to expend the amounts in the schedule to pay substance abuse treatment costs. No funding would be provided in the 2015-17 biennium for this purpose. Require DHS to address, in its 2017-19 biennial budget request, any future fiscal impact resulting from this provision.

Finally, specify that all FoodShare recipients are considered "welfare recipients" for the purposes of 21 USC 862b. This provision in federal law provides that, notwithstanding any other provision of law, states shall not be prohibited by the federal government from testing welfare recipients for use of controlled substances, nor for sanctioning welfare recipients who test positive for use of controlled substances.

Veto by Governor [E-76]: Delete the requirement that the policy only be applied to an individual for whom there is reasonable suspicion of abuse of a controlled substance without a valid prescription. In addition, modify the bill to delete the language indicating that treatment be state-sponsored.

[Act 55 Sections: 679c, 1832p, 1833, and 9118(5)]

[Act 55 Vetoed Section: 1833]

8. FRAUD PREVENTION AND INVESTIGATION ALLOCATIONS TO IM CONSORTIA

GPR	$500,000
FED	500,000
Total	$1,000,000

Joint Finance/Legislature: Provide $500,000 ($250,000 GPR and $250,000 FED) annually to increase the amount of funding that would be budgeted for the DHS to provide to local units of government to conduct medical assistance (MA) and FoodShare fraud prevention and investigation activities.

The DHS fraud prevention and investigation program (FPIP) is currently budgeted $500,000 ($250,000 GPR and $250,000 FED) annually to support statewide fraud prevention activities conducted by agencies, other than Milwaukee Enrollment Services (MiLES), that administer MA and FoodShare. Annually, DHS allocates this funding based on each agency's percentage of the statewide income maintenance (IM) caseload. Local funding that supports these activities is eligible for federal matching funds.

Each IM consortium determines what staff will conduct FPIP investigations, which may include agency staff, contracted staff, local law enforcement, or some combination. Recoveries made as a result of these activities are divided between the federal government, the state, and the local agencies. The federal, state and local share of these recoveries depend on whether the recovered benefits were initially paid from FoodShare or MA, and whether the recovery was the result of client error, fraud, or an error committed by the administering agency.

9. REPLACEMENT COSTS OF FOODSHARE EBT CARDS

GPR	- $341,300
FED	- 341,200
PR	682,500
Total	$0

Joint Finance/Legislature: Require DHS to deduct the allowable costs the state incurs, as determined by DHS, to replace a lost or stolen electronic benefit transfer (EBT) card from the FoodShare benefit amount provided on the EBT card. Specify that this provision would first apply to requests to replace lost or stolen EBT cards received by DHS or its contracted entities on July 1, 2016.

Reduce funding budgeted for DHS contracted services by $227,500 (-$113,800 GPR and -$113,700 FED) in 2015-16 and $455,000 (-$227,500 GPR and -$227,500 FED) in 2016-17 to reflect estimates of cost savings the state would realize by requiring FoodShare recipients, rather than state and federal FoodShare administration funds, to pay for the costs of replacing lost or stolen EBT cards.

Create a continuing PR appropriation to support DHS contracted services, to which moneys transferred from EBT accounts for the costs of replacement cards would be credited to replace the GPR and FED funding currently budgeted to support the costs of replacing cards. Estimate that $227,500 PR in 2015-16 and $455,000 PR in 2016-17 would be available to support contracted services from funding transferred from EBT accounts.

FoodShare enrollees use EBT cards to purchase eligible products with their monthly FoodShare benefit allotment. Currently, if an individual requests a replacement card, DHS incurs the cost associated with providing the replacement card, and does not assess a fee to the individual who makes the request. DHS estimates that this cost is currently approximately $3.50 per card, which includes the cost of the card, postage, an envelope, and an insert. These costs are funded from

50% GPR and 50% federal matching funds budgeted for the administration of the FoodShare program. The state replaced approximately 130,000 lost or stolen EBT cards from March, 2014 to February, 2015.

Under federal law, states may charge FoodShare recipients the cost of replacing the EBT card to the EBT account, up to the cost that the state incurs to replace the card. In order to implement this policy, DHS would be required to inform the U.S. Department of Agriculture's Food and Nutrition Service of its plan to implement the policy, including the procedures that would be used to account for card replacement fees, as well as the replacement threshold, frequency, and circumstances under which the fee would be applicable.

[Act 55 Sections: 685r, 1832r, and 9318(4f)]

10. FRAUD PREVENTION -- ADVANCED ANALYTICS SYSTEM

GPR	$500,000
FED	4,500,000
Total	$5,000,000

Joint Finance/Legislature: Provide $5,000,000 ($500,000 GPR and $4,500,000 FED) in 2015-16 for the procurement and implementation of an advanced analytics system for the purpose of minimizing provider and beneficiary fraud in the state's MA program, or for verifying the identification of MA and Medicare beneficiaries prior to their receiving covered services.

11. TRANSFER PRIOR AUTHORIZATION

Joint Finance/Legislature: Transfer 2.75 GPR positions and 8.25 FED positions from the Office of the Inspector General (OIG) to the Division of Medicaid Services (DMS), effective March 31, 2016, to reflect the transfer of positions and funding related to prior authorization from OIG to DMS. Transfer $272,700 ($68,200 GPR and $204,500 FED) in 2015-16 and $1,090,700 ($272,700 GPR and $818,000 FED) in 2016-17 from OIG to DMS.

Institutions and Mental Health

1. MENTAL HEALTH INSTITUTES FUNDING SPLIT

	Funding	Positions
GPR	- $6,644,000	- 77.96
PR	6,644,000	77.96
Total	$0	0.00

Governor/Legislature: Reduce funding by $3,068,100 GPR in 2015-16 and $3,575,900 GPR in 2016-17 and provide corresponding PR funding increases to adjust funding at the Mendota and Winnebago mental health institutes (MHIs) to reflect an increase in the percentage of patients whose care is funded with PR, rather than GPR. Convert 71.6 GPR positions to PR positions in 2015-16, and an additional 6.36 GPR positions to PR positions in 2016-17, so that a

total of 77.96 GPR positions would be converted to PR positions in 2016-17.

The share of MHI costs funded by GPR and PR is based on the composition of the patient population. The state is responsible for the cost of caring for forensic patients, which it funds with GPR. The cost of caring for civilly-committed patients is funded from program revenues paid by counties and third-party payers, including MA for MA-eligible populations. In general, the PR-funded patients have increased as a percentage of the total patient population, accounting for the funding and position shift.

The following table shows the administration's estimates of patient populations at each MHI, by year and fund source, upon which the funding and position adjustments are based.

Population Estimates -- Mental Health Institutes

	2015-16			2016-17		
	GPR	PR	Total	GPR	PR	Total
Mendota						
Forensic Programs	252.2	7.0	259.2	252.2	7.0	259.2
Geropsychiatric Unit	0.0	15.0	15.0	0.0	15.0	15.0
Juvenile Treatment Center	28.8	0.0	28.8	28.8	0.0	28.8
Total	281.0	22.0	303.0	281.0	22.0	303.0
Percentage of Total Patients	93%	7%	100%	93%	7%	100%
Winnebago						
Forensic Programs	90.0	34.0	124.0	90.0	39.0	129.0
Adult Civil Units	0.0	39.0	39.0	0.0	39.0	39.0
Children's Units	0.0	44.0	44.0	0.0	47.0	47.0
Total	90.0	117.0	207.0	90.0	125.0	215.0
Percentage of Total Patients	43%	57%	100%	42%	58%	100%

2. FUEL AND UTILITIES

GPR	- $5,849,000

Governor/Legislature: Reduce funding by $2,961,500 in 2015-16 and $2,887,500 in 2016-17 to reflect a reestimate of GPR-funded fuel and utilities costs for the Department's care facilities. As base GPR funding for these costs is $8,238,800, the bill would provide $5,277,300 GPR in 2015-16 and $5,351,300 GPR to fund these costs. The bill maintains base funding for fuel and utility costs funded from PR sources ($6,928,800 annually).

3. CONTRACTED MENTAL HEALTH SERVICES [LFB Paper 375]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$5,381,500	- $835,800	$4,545,700

Governor: Provide $2,011,100 in 2015-16 and $3,370,400 in 2016-17 above base funding of $10,729,200 to fund projected increases in the costs of competency examinations, restoration to competency treatment, conditional release, and supervised release services for mental health clients served by DHS facilities. Generally, the Department's estimates for these services are based on the assumption that the per-client costs will increase at 2.1% annually, and that caseloads will increase based on historical trends.

Outpatient Competency Examination. Chapter 971 of the statutes prohibits courts from trying, convicting, or sentencing an individual if the individual lacks substantial mental capacity to understand the proceedings or assist in his or her own defense. Courts may order DHS to conduct competency examinations, which may be performed either on an inpatient basis by DHS staff at the state mental institutes, or on an outpatient basis in jails and locked units of other facilities by contracted staff. This item would increase funding for contracted examinations.

Treatment to Competency Services. DHS contracts with a vendor to provide outpatient treatment services to individuals who are determined to be not competent to proceed to a criminal trial if a court determines that the individual is likely to be competent within 12 months, or the maximum sentence specified for the most serious offense with which the defendant is charged.

Conditional Release Services. The conditional release program provides treatment to individuals who have been found not guilty by reason of mental disease or defect and are either immediately placed on conditional release following the court's finding, or following release from one of the state's mental health institutes. DHS contracts with five organizations, each of which provides services in one of five regions of the state, to provide these services.

Supervised Release Services. The supervised release program provides community-based treatment to individuals who are found to be sexually violent persons (SVPs) under Chapter 980 of the statutes. SVPs are committed to DHS and provided institutional care at the Sand Ridge Secure Treatment Center in Mauston, but may petition the court for supervised release if at least 12 months have elapsed since the initial commitment order was entered, the most recent release petition was denied, or the most recent order for supervised release was revoked.

Corrections Contract Costs for Supervision. DHS contracts with the Department of Corrections (DOC) to supervise individuals on conditional and supervised release, and to provide transportation escort and global positioning system (GPS) services to individuals on supervised release.

Joint Finance/Legislature: Reduce funding by $377,300 in 2015-16 and $458,500 in 2016-17 to reflect a reduction in the estimated number of individuals who will be on conditional release in the 2015-17 biennium.

The following table summarizes the estimates of clients and costs DHS will incur to provide contracted services in the 2015-17 biennium under Act 55.

Contracted Services for Mental Health Clients -- Act 55

	2015-16			2016-17		
	Number	Average Cost	Total	Number	Average Cost	Total
Outpatient Competency Exams	1,346	$1,310	$1,763,300	1,411	$1,340	$1,890,700
Restoration to Competency	100	10,820	1,082,000	118	11,050	1,303,900
Conditional Release Treatment	324	14,260	4,620,200	336	14,560	4,892,200
Supervised Release Treatment	52	67,410	3,505,300	59	68,830	4,061,000
Subtotal			$10,970,800			$12,147,800
DOC Supervision Contracts			$1,392,200			$1,493,300
Total Funding Provided			$12,363,000			$13,641,100
Base Funding			$10,729,200			$10,729,200
Act 55 Change to Base			$1,633,800			$2,911,900

4. DEBT SERVICE [LFB Paper 175]

GPR	- $4,310,800

Governor/Legislature: Reduce funding by $677,000 in 2015-16 and $3,633,800 in 2016-17 to reflect an estimate of debt service payments on bonds issued for DHS facilities. Base debt service funding is $22,877,400.

5. SUPPLIES AND SERVICES AT DHS INSTITUTIONS [LFB Paper 375]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	- $2,615,400	$754,400	- $1,861,000
PR	3,672,400	- 1,267,100	2,405,300
Total	$1,057,000	- $512,700	$544,300

Governor: Reduce funding by $1,050,200 (-$2,362,300 GPR and $1,312,100 PR) in 2015-16 and increase funding by $2,107,200 (-$253,100 GPR and $2,360,300 PR) in 2016-17 to reflect estimates of the cost of providing non-food supplies and services for residents at the three State Centers for People with Developmental Disabilities (Centers), the two mental health institutes (MHIs), the Wisconsin Resource Center, and the Sand Ridge Secure Treatment Center. This funding supports medical services (including hospitalizations, diagnostic testing, and outpatient medical visits), drugs, clothing, and other supplies. The Department projects a reduction in GPR expenditures at these facilities primarily because the agency's base budget for these services exceeds anticipated expenditures at Sand Ridge and at the MHIs. The increases in PR funding are due primarily to an increase in the population of civil commitments at the Winnebago MHI and projected increases in drug and medical services costs for residents at the

State Centers.

Joint Finance/Legislature: Increase funding by $330,100 GPR in 2015-16 and $424,300 GPR in 2016-17 and decrease funding by $312,500 PR in 2015-16 and $954,600 PR in 2016-17 to reflect revised population and cost estimates.

[Act 55 Sections: 672, 673, 1881, 1883k, 9118(7), 9418(3), and 9418(4)]

6. CIVIL COMMITMENT COSTS OF NONRESIDENTS

GPR	$215,600

Governor/Legislature: Increase funding by $107,800 annually to reflect an estimate of the cost of reimbursing treatment facilities for the cost of providing services to non-state residents who are civilly committed for reasons of mental illness, drug dependency, or developmental disability. Counties are responsible for the costs of providing care to their residents who are civilly committed, but the state assumes responsibility of persons who are not state residents and who are civilly committed while in the state. The bill would provide a total of $507,800 annually for this purpose in a sum sufficient appropriation.

Currently, two sum sufficient appropriations support these reimbursements -- one that funds services provided to civilly committed individuals with developmental disabilities and one that funds services to civilly committed individuals with mental illness or drug dependency. The bill would repeal the first appropriation and modify the second so that a single appropriation would fund reimbursements for all non-residents who are civilly committed and receive services at treatment facilities.

7. FOOD AT DHS INSTITUTIONS [LFB Paper 375]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	- $107,800	$84,000	- $23,800
PR	179,800	- 17,200	162,600
Total	$72,000	$66,800	$138,800

Governor: Reduce funding by $23,100 (-$90,200 GPR and $67,100 PR) in 2015-16 and increase funding by $95,100 (-$17,600 GPR and $112,700 PR) in 2016-17 to reflect an estimate of the cost of providing meals for residents in the 2015-17 biennium at the State Centers for the Developmentally Disabled, the mental health institutes, the Wisconsin Resource Center, and the Sand Ridge Secure Treatment Center. Estimates are based on population projections and inflation.

Joint Finance/Legislature: Increase funding by $34,400 ($42,900 GPR and -$8,500 PR) in 2015-16 and $32,400 ($41,100 GPR and -$8,700 PR) in 2016-17 to reflect revised population estimates.

8. MENDOTA JUVENILE TREATMENT CENTER

Governor/Legislature: Modify a statutory provision that identifies the amount of funding the Department of Corrections is required to transfer to DHS to support the Mendota Juvenile Treatment Center (MJTC), to require PR transfers of $2,929,200 in 2015-16 and $2,997,600 in 2016-17, an increase from $2,772,800 in 2014-15. The amount of GPR funding Corrections is required to transfer annually ($1,365,500) would not change. Consequently, Corrections would be required to transfer a total of $4,294,700 ($1,365,500 GPR and $2,929,200 PR) in 2015-16 and $4,363,100 ($1,365,500 GPR and $2,997,600 PR) in 2016-17 to support MJTC.

The net funding changes in the annual statutory allocation, compared to the 2014-15 allocation ($156,400 in 2015-16 and $224,800 in 2016-17) reflect standard budget adjustments for DHS staff costs associated with operating this unit.

[Act 55 Section: 1472]

9. MENTAL HEALTH CRISIS SERVICE GRANTS AND EMERGENCY DETENTION PROCEDURES [LFB Paper 376]

PR	$1,500,000

Governor: Provide $1,500,000 in one-time funding in 2015-16 for DHS to distribute as grants to counties for mental health crisis services. Funding for these grants would be budgeted in a program revenue appropriation that supports the Department's institutional operations. This appropriation is one of the principal funding sources for the state's mental health institutes, and reflects the receipt of various revenue sources, including county payments and Medical Assistance program reimbursement for services provided by those facilities. In addition, make the following statutory changes.

Crisis Assessments. Modify provisions related to the emergency detention of persons for reasons of mental illness, drug dependency, or developmental disability to specify that a county human services department may not approve the detention of a person unless a physician who has completed a residency in psychiatry, a licensed psychologist, or a mental health professional has performed a crisis assessment on the individual and agrees for the need for detention.

Emergency Detention Procedures in Milwaukee County. Repeal provisions that establish special procedures for emergency detention in Milwaukee County and a pilot program for alternative emergency detention procedures in Milwaukee County. Under this item, the Milwaukee County emergency detention procedures would be the same as for other counties. In Milwaukee County, the treatment director of the treatment facility must determine, within 24 hours, if the person meets the criteria for detention, whereas in all other counties, the treatment director is not required to make an affirmative determination on the question of whether the emergency detention criteria have been met within a specified time period, but must discharge the person when, upon the advice of the treatment staff, he or she determines that the criteria are no longer met. In all cases, the person may not be held in detention for a period exceeding 72 hours from the time that the person was taken into custody, exclusive of Saturdays, Sundays, and legal holidays, unless a probable cause hearing for involuntary civil commitment has been held.

Under the pilot program, which, under current law, will expire after May 1, 2016, the treatment director of a treatment facility may take a person into custody for the purposes of emergency detention.

Specify that all of these provisions would take effect on July 1, 2016.

The administration indicates that the crisis service grants are related to the statutory changes to the emergency detention procedures, although the bill does not create specific requirements for allocation of the funds by the Department or for the use of the funds by counties.

Joint Finance/Legislature: Modify the list of persons who are authorized to conduct a crisis assessment ("physician who has completed residency in psychiatry, a licensed psychologist, or a mental health professional") to modify "mental health professional" with the phrase "as determined by the Department" and specify that a crisis assessment may be conducted in person, by telephone, or by telemedicine or video conferencing technology.

Delete the provision that would eliminate the alternative emergency detention procedures for Milwaukee County (to retain current law) and delete the elimination of the Milwaukee County emergency detention pilot program. Extend the sunset date for the pilot program from May 1, 2016, to July 1, 2017.

[Act 55 Sections: 672, 673, 1881 ,1883k, 9118(7), 9418(3), and 9418(4)]

10. CONSOLIDATE COMMUNITY MENTAL HEALTH PROGRAMS [LFB Paper 377]

Governor: Consolidate base funding for community mental health services by repealing several programs and funding allocations and transferring base funding from these programs to a funding allocation under the state's community aids program, effective January 1, 2016.

Repealed Programs. Repeal the "treatment funds for mentally ill persons" program, which requires DHS to allocate the following to county human service agencies: (a) $10,914,700 in each fiscal year for the care of persons living in a nursing home or intermediate care facility that is classified as an institute for mental disease (IMD) or for community-based care of mentally ill persons meeting certain criteria; and (b) funds equal to the amount of the state's share of Medical Assistance program costs for noninstitutional medical services for residents of nursing or intermediate care facilities that are classified as IMDs.

Repeal the "relocation services for individuals with mental illness" program, which requires the Department to distribute not more than $830,000 in each fiscal year for community-based services for persons with mental illness and who are not eligible for services under the community integration program.

Delete references to these two programs in the DHS mental health treatment services appropriation and specify, instead, that this appropriation may be used to support mental health treatment services at a county-operated institution for mental disease as selected by the

Department ($1,551,500 on an annualized basis). Currently, the only county-operated institution for mental disease is the Trempealeau County Health Care Center. The Department indicates that this facility would continue to receive the same level of support as it currently does under this provision.

Repeal an appropriation that funds the community support programs and psychosocial services, effective June 30, 2016, and delete all statutory references to that appropriation, including a provision that authorizes the DHS to transfer unexpended moneys from this appropriation at the end of the fiscal year to the Department's appropriation for grants for community programs to be used for supported employment opportunities for individuals who are severely disabled.

Community Aids Allocation. Expand the statutory purpose of community aids program to explicitly include community mental health services. Require DHS to distribute not less than $24,348,700 in each fiscal year for community mental health services. Provide that in 2015-16, the first fiscal year of the consolidation, the Department may distribute one-half of that amount ($12,174,350), after January 1, 2016.

The funding transfers in the bill are shown in the following table.

	2015-16	2016-17
Mental Health Treatment Services	-$4,006,800	-$8,013,700
Community Support Programs and Psychosocial Services	-1,878,800	-3,757,500
Community Options Program (Mental Health/Substance Abuse)	-6,288,800	-12,577,500
Community Aids -- Community Mental Health Services	$12,174,400	$24,348,700

Another provision in the bill would repeal the family support program and consolidate funding for children's long-term care services to create a children's community options program. Since some COP funding is currently used to provide services for persons with mental illness or substance abuse disorders, the bill would transfer a portion of the COP funding to support community mental health services. The fiscal effect of that transfer is reflected in this item and shown in the table above.

The administration indicates that the intent of this provision is to consolidate several different programs into one appropriation and one programmatic distribution, but to provide the same allocation to individual counties as DHS currently provides from the programs that would be repealed. The bill would not require DHS to maintain the current distribution and would not specify a distribution mechanism. Counties would not be subject to the same requirements with respect to the use of funds distributed under the eliminated programs.

Joint Finance/Legislature: Require the Department to consult with the Wisconsin Counties Association and other persons and organizations with an interest in mental health services before developing a method for distributing community mental health services funds in 2016 and thereafter. Require the Department, before implementing a distribution method, to submit the proposed distribution method to the Joint Committee on Finance. Specify that if the Co-chairpersons of the Committee do not notify the Department within 14 working days after the

date of the submittal that the Committee has scheduled a meeting for the purpose of reviewing the proposed distribution method, the Department is required to implement the distribution method as proposed. Specify that if the Co-chairpersons notify the Department that the Committee has scheduled a meeting for the purpose of reviewing the proposed distribution method, the Department may implement the proposed distribution method only as approved by, or as modified and approved by, the Committee.

Veto by Governor [E-85]: Delete the requirement that the Department consult with the Wisconsin Counties Association and other interested parties prior to developing a method for distributing funds, as well as the requirement that the Department submit the proposed method to the Joint Committee on Finance for approval.

[Act 55 Sections: 693, 694, 701, 702, 1518, 1519, 1523, 1524, 1536, 1537, 1633, 1802, 1897 thru 1900, 9118(1), and 9418(1)]

[Act 55 Vetoed Section: 9118(1q)]

11. OFFICE OF CHILDREN'S MENTAL HEALTH

Governor: Specify that the Director of the Office of Children's Mental Health be appointed by the Secretary of the Department of Health Services and is to serve at the pleasure of the Secretary, rather than, under current law, vesting the appointment authority with the Governor. The Office was created by 2013 Act 20 to coordinate initiatives related to mental health services for children across state agencies. The Office has 4.0 positions and is housed in DHS.

Joint Finance/Legislature: Delete provision.

Public Health and Other Programs

1. HIV/AIDS PROGRAM

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	- $10,078,600	$300,000	- $9,778,600

Governor: Reduce funding by $5,039,300 annually for the AIDS/HIV drug assistance program (ADAP) and the health insurance premium subsidy program. 2013 Act 20 provided an additional $5,039,300 GPR in 2014-15 to address a projected (all funds) shortfall in the program, but program costs in the current biennium have been less than projected under Act 20, permitting DHS to carry over federal and program revenues from the current biennium to fund expenses in

the 2015-17 biennium. The total GPR funding for ADAP and the health insurance premium subsidy program would be $1,306,200 annually, the amount that was budgeted in 2013-14.

ADAP pays for certain drugs provided to Wisconsin residents who have tested positive for HIV and who have household income under 300% of the federal poverty level (FPL). The health insurance premium subsidy program subsidizes private insurance premiums for individuals with household family income under 300% of the FPL if they have an HIV-related condition that required them to reduce or end their employment. These programs are supported by GPR, federal Ryan White grants funds, PR from rebates on ADAP drug purchases, and Medicaid or other insurance payments. The administration projects ADAP and insurance program costs (all funds) will total approximately $16.2 million in 2015-16, and approximately $17.8 million in 2016-17.

Joint Finance/Legislature: Increase funding for Mike Johnson life care and early intervention services grants by $150,000 GPR annually. Increase the statutory limit on the amount of funding DHS may provide annually for those grants, from $3,569,900 to $3,677,000 in each fiscal year. In state fiscal year 2014-15, $3,527,000 GPR was budgeted for these grants for case management, support services, and core medical services provided by AIDS service organizations (ASOs). Currently, AIDS Resource Center of Wisconsin is the only ASO in the state.

[Act 55 Section: 4037r]

2. SUPPLEMENTAL SECURITY INCOME (SSI) [LFB Paper 380]

GPR	$9,898,200
PR	- 3,168,600
Total	$6,729,600

Governor/Legislature: Provide $2,099,700 ($3,684,000 GPR and -$1,584,300 PR) in 2015-16 and $4,629,900 ($6,214,200 GPR and -$1,584,300 PR) in 2016-17 to fund the projected cost of supplemental security income (SSI) state benefit payments. SSI provides federal and GPR-funded benefits to low-income individuals who are elderly, blind, or disabled. Recipients with dependent children also receive a "caretaker supplement" payment, supported by federal temporary assistance to needy families (TANF) funds from the Department of Children and Families.

Basic State Supplement. Provide $3,684,000 GPR in 2014-15 and $6,214,200 GPR in 2016-17 to fully fund projected costs of state supplemental SSI benefits. In February, 2015, approximately 120,000 individuals received state supplemental payments, including the basic supplement ($83.78 per month for single individuals) and the exceptional expense benefit ($95.99 per month for single individuals). Base funding for these payments is $151,607,400 GPR, budgeted in a sum sufficient appropriation. The administration projects payments of $155,291,400 GPR in 2015-16 and $157,821,600 GPR in 2016-17.

Caretaker Supplement. Delete $1,584,300 PR annually to reflect estimates of the amounts needed to fully fund projected SSI caretaker supplement benefit payments. DHS provides SSI recipients with a monthly payment of $250 for the first dependent child and $150 for each additional dependent child. Base TANF funding for the caretaker supplement is $32,017,700. The administration projects caretaker supplement benefit payments will total $30,433,400 PR in each year of the 2015-17 biennium, which is the amount DHS expended for these payments in

2013-14.

3. TRANSFER REGULATION OF FOOD, LODGING AND RECREATIONAL ESTABLISHMENTS TO DATCP [LFB Paper 381]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
PR	- $3,400,900	- 35.00	- $3,900	0.00	- $3,404,800	- 35.00

Governor: Reduce funding by $3,400,900 in 2016-17, and delete 35.0 positions, beginning in 2016-17, to reflect the transfer of regulatory responsibility for restaurants, lodging establishments and certain recreational establishments from DHS to the Department of Agriculture, Trade and Consumer Protection (DATCP), effective July 1, 2016. As part of this proposal, the bill would provide DATCP $3,432,500 in 2016-17 and 35.0 positions, beginning in 2016-17, which is summarized under "Agriculture, Trade and Consumer Protection." Currently DHS issues permits and enforces state statute and administrative code for these establishments, and contracts with local public health departments to perform certain inspection and enforcement activities.

The bill contains the following statutory changes.

Transfer Authority to DATCP. Transfer provisions relating to DHS authority to regulate hotels, tourist rooming houses, bed and breakfast establishments, vending machine commissaries, and campgrounds, camping resorts, recreational and educational camps, and public swimming pools to DATCP and codify these provisions under Chapter 97. The bill would not make substantive changes to the regulation of these entities.

Repeal references to "restaurant" and "temporary restaurant" from the current law provisions in Chapter 254. Instead, include those types of establishments in the definition of "retail food establishments," which are currently regulated by DATCP.

Repeal references to the these entities in the DHS program revenue appropriation that funds current regulation activities from fees DHS collects, and, create corresponding references in the DATCP program revenue appropriation program for its current food regulation activities.

Establish, for campgrounds, camping resorts, recreational and educational camps, and public swimming pools, a forfeiture of $50 per day for failure to comply with an order under Chapter 97 (in addition to potential revocation of the relevant license). Those establishments are currently subject to a forfeiture of $10 per day for noncompliance with a DHS order.

Finally, for those establishments, impose on a person the following fines for a violation of the chapter: (a) not less than $100 nor more than $1,000 or imprisoned for not more than six months for the first offense; and (b) not less than $500 nor more than $5,000 or imprisoned for not less than 30 days and not more than one year in the county jail (or both) for each subsequent offense. Currently, the fine for violation of the provisions of 254.47 is not less than $25 and not

more than $250.

DOA Secretary Transfer Authority. Transfer to DATCP all incumbent DHS employees performing duties that the Secretary of the Department of Administration (DOA) determines to be primarily related to food, lodging, and recreation oversight, and the full-time equivalent positions held by those employees, on July 1, 2016. Specify that the transferred employees would have the same rights and status under state employment relations statutes that they had prior to the transfer, and that no transferred employee who had attained permanent status would serve a probationary period.

Transfer from DHS to DATCP all assets and liabilities, tangible personal property (including records), contracts in effect, and pending matters that the DOA Secretary determines are primarily related to food, lodging, and recreation oversight, on July 1, 2016. Require DATCP to carry out any contractual obligation unless modified or rescinded to the extent allowed under the contract. Specify that all materials submitted to, or actions taken by DHS with respect to a pending matter would be considered as having been submitted to or taken by DATCP.

Provide that all rules promulgated under Chapters 172, 175, 178, 192, 195, 196, 196 appendix, 197 and 198 of the Administrative Code, and all other rules promulgated and orders issued by DHS that the DOA Secretary determines are primarily related to food, lodging, and recreation oversight, that are in effect on July 1, 2016, would remain in effect until their specified expiration dates or until amended or repealed by DATCP.

Cross-References and Minor Statutory Changes. The bill would make multiple changes to cross-references to reflect renumbered statutory provisions, change current references from "permits" to "licenses," as they relate to the regulation of establishments by DATCP, and make minor changes to current statutory provisions.

Transfer of Position Authority within DHS. Transfer $37,800 PR annually and 0.50 PR position, beginning in 2015-16, within the current PR funded appropriation that is currently budgeted for food, lodging, and recreation oversight activities to instead support other regulatory activities and the state vital records program.

Joint Finance/Legislature: Include provision. Reduce funding by an additional $3,900 in 2016-17 to fully delete funding for the transferred activities from the DHS budget.

In addition, create a Food Safety Advisory Council in DATCP, effective July 1, 2016. Require the DATCP Secretary to appoint council members, to serve at the pleasure of the Secretary, reflecting a broad representation of the persons regulated under Subchapter II of Chapter 97 of the statutes (the DATCP statutes related to food safety, as reorganized under the bill). Require the Council to meet at least quarterly, and advise the DATCP Secretary on all aspects of food safety, including the fees charged to the persons regulated under Subchapter II of Chapter 97 of the statutes.

Prohibit DHS or any local health department designated as an agent of the Department, from the effective date of the bill through July 1, 2016, from modifying any fee established for the regulation of restaurants or temporary restaurants, or for a certificate of food protection

practices. Prohibit DATCP, or any local health department designated as an agent of the Department, from modifying the following fees: (a) from the effective date of the bill through July 1, 2016, any fees for the regulation of retail food establishments and other food-related activities (in ss. 97.12 through 97.57 of the statutes); and (b) from July 1, 2016, through July 1, 2017, the fees established under newly-created Subchapter II of Chapter 97. Collectively, these provisions would implement a two-year freeze on all food safety-related fees that are contained under Subchapter II of Chapter 97, as created under the bill.

Veto by Governor [C-51]: Delete the provision creating of a Food Safety Advisory Council in DATCP.

Delete the DATCP fee freeze that would have applied to retail food establishments in 2015-16 and all food safety-related fees in 2016-17, (but maintain the one-year fee freeze for DHS that applies to 2015-16). This action results in a one-year freeze on fees charged by DHS for restaurants, temporary restaurants, and certificates of food protection practices.

[Act 55 Sections: 482, 670, 1055, 1455, 1854, 1974 thru 1980, 2472, 2515, 2596, 2606, 2612, 2616, 2617, 2641 thru 2648, 2659 thru 2680, 2682, 2692, 2694 thru 2697, 2699, 2700, 2705 thru 2707, 2710, 2714, 2715, 2720, 3105 thru 3107, 3122, 3422 thru 3424, 3426 thru 3428, 3430 thru 3434, 4033, 4034, 4036, 4040, 4045, 4047, 4050 thru 4105, 4318, 4353 thru 4355, 4721, 9118(2) & (10u), and 9418(2)]

[Act 55 Vetoed Sections: 132m, 9102(3q), and 9402(1v)]

4. TRANSFER REGULATION OF TATTOOING, BODY PIERCING AND TANNING TO DFIPS [LFB Paper 577]

Governor: Transfer the regulatory responsibility for tattooists and tattoo establishments, body-piercers and body piercing establishments, and tanning facilities from DHS to the proposed Department of Financial Institutions and Professional Standards (DFIPS), effective January 1, 2016. Renumber current statutes relating to these professions to a new chapter, Chapter 463 ("Body Art and Tanning Facilities") under DFIPS. Transfer to DFIPS statutory requirements for denying or revoking licenses, and provisions that permit local public health departments to act as agents of the Department.

Change the manner in which permit or license fees would be set for the professions and establishments in this item from administrative rule to the current biennial fee-setting structure that applies to professions regulated by the Department of Safety and Professional Services. Specify that DHS would establish fees for issuance and renewal of licenses and permits for 2015 and 2016 by rule.

Repeal references to the statutes for tattooing, body piercing and tanning from program revenue appropriation that supports DHS licensing, review and certifying activities. The bill would not delete any PR expenditure or position authority.

DOA Secretary Transfer Authority. Transfer from DHS to DFIPS all assets and liabilities,

tangible personal property (including records), contracts in effect, and pending matters that the DOA Secretary determines are primarily related to the regulation of tattooing, body piercing and tanning, on January 1, 2016. Require DFIPS to carry out any contractual obligation unless modified or rescinded to the extent allowed under the contract. Specify that all materials submitted to, or actions taken by DHS with respect to a pending matter would be considered as having been submitted to or taken by DFIPS.

Provide that all rules promulgated under HS 161 and 173, and all other rules promulgated and orders issued by DHS that the DOA Secretary determines are primarily related to the regulation of tattooing, body piercing and tanning, that are in effect on January 1, 2016 would remain in effect until their specified expiration dates or until amended or repealed by DFIPS.

Cross-References and Technical Amendments. The bill would make multiple changes to cross-references to reflect renumbered statutory provisions, change the term "permit" to "license," and other minor changes to current statutory provisions.

Joint Finance/Legislature: Modify the bill to transfer regulatory responsibility for tattooists and tattoo establishments, body-piercers and body piercing establishments, and tanning facilities from DHS to the Department of Safety and Professional Services (DSPS).

This provision would transfer body art and tanning regulation to DSPS, under the same framework as described above for the proposed transfer to DFIPS. The Joint Finance Committee removed the creation of DFIPS from the bill, as summarized in other items under the DSPS section.

[Act 55 Sections: 669, 1454, 1853, 2471, 3121, 4031, 4032, 4041 thru 4044, 4048, 4108, 4317, 4377, 4524, 4525, 9118(3), and 9418(2f)]

5. TRANSFER COMMUNITY-BASED RESIDENTIAL FACILITY AND HOSPICE PLAN REVIEW TO DHS

Governor/Legislature: Transfer from DSPS to the Department of Health Services the responsibility to conduct plan reviews of all capital construction and remodeling of structures that are owned or leased for the operation of a hospice. Require DHS to promulgate rules to establish a fee schedule for conducting these plan reviews. Exempt hospices and community-based residential facilities (CBRFs) from the requirement to submit any essential drawings, calculations, and specifications for public buildings, public structures, and places of employment to DSPS. These provisions would take effect January 1, 2016, or the day after publication of the bill, whichever is later.

Under current law, DHS conducts plan reviews for hospitals, nursing homes, and CBRFs, but not hospices. Unlike most other public buildings, public structures, and places of employment, hospitals and nursing homes are not required to submit materials to DSPS for plan reviews.

[Act 55 Sections: 1879, 2693, and 9418(2f)]

6. CONTRACT WITH STATE LABORATORY OF HYGIENE [LFB Paper 686]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
GPR	$3,593,400	- $3,593,400	$0

Governor: Provide $3,593,400 in 2016-17 in the Division of Public Health's general program operations appropriation for DHS to purchase diagnostic testing services from the Wisconsin State Laboratory of Hygiene (WSLH). These services are currently funded by GPR budgeted directly in WSLH. The bill would reduce GPR and increase PR expenditure authority in WSLH by the amount of the contract, and would transfer the WSLH from the UW System to the Department of Agriculture, Trade and Consumer Protection.

Joint Finance/Legislature: Delete provision.

7. REPEAL HEALTH CARE PROVIDER FEES FOR DATA COLLECTION AND DISSEMINATION [LFB Paper 383]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
FED	$217,800	1.00	$0	0.00	$217,800	1.00
PR	- 312,400	- 1.00	0	0.00	- 312,400	- 1.00
Total	- $94,600	0.00	$0	0.00	- $94,600	0.00
GPR-REV	$0		$1,100,000		$1,100,000	
PR-REV	- 2,067,200		0		- 2,067,200	

Governor: Repeal a provision that requires DHS to assess a fee of up to $75 per year on health care providers (other than hospitals and ambulatory surgical centers) from whom the Department collects data under Chapter 153 of the statutes. Currently, DHS assesses physicians an annual fee of $70, but does not assess the fees on other health care providers. In 2014, approximately 14,800 physicians paid the $70 fee, resulting in program revenues totaling approximately $1,033,600. Consequently, the administration estimates that this change will reduce program revenues to DHS by approximately that amount annually.

Repeal provisions that: (a) require DHS to assess the total estimated amount that the Department will spend on data collection, database development and maintenance, generation of data files and standard reports, orientation and training, and contracting with a data organization to analyze and report health care claims information, minus certain DHS administrative costs; and (b) direct DHS to work with the Department of Safety and Professional Services to develop a mechanism for collecting assessments.

As part of this item: (a) delete $263,900 PR annually and 2.0 PR positions, beginning in 2015-16, from the appropriation to which the physician fees are credited: and (b) provide

$216,600 ($108,900 FED and $107,700 PR) annually, and 2.0 positions (1.0 FED position and 1.0 PR position) beginning in 2015-16, to continue funding the state's E-Health manager position, and the portions of the State Registrar and an office operations associate position currently supported by the physician fee revenue. The bill would not repeal the appropriation from which these funds are budgeted, and would maintain PR expenditure authority ($1,738,100 PR in 2015-16 and $1,334,000 PR in 2016-17), with the intent of allowing DHS to spend any available PR balances in that appropriation carried over from the current biennium.

Joint Finance/Legislature: Include provision. In addition, require DHS to transfer $1,100,000 from the physician assessment PR appropriation to the general fund in 2015-16.

[Act 55 Sections: 671, 3484, and 9218(2c)]

8. REQUIREMENT FOR PHARMACISTS TO UPDATE IMMUNIZATION REGISTRY

Governor: Require a pharmacist or pharmacy that administers a vaccine in accordance with the state immunization program to a person six to 18 years of age to update the Wisconsin immunization registry within 24 hours of administering the vaccine.

Joint Finance/Legislature: Extend the deadline that would apply to the proposed reporting requirement to within seven days of administering a vaccine, rather than within 24 hours.

[Act 55 Section: 4037]

9. PRETRIAL INTOXICATED DRIVER INTERVENTION GRANT PROGRAM [LFB Paper 382]

Governor/Legislature: Transfer administration of the pretrial intoxicated driver intervention grant program from the Department of Transportation to DHS. Specify that DHS would fund grants under the program from a DHS GPR appropriation that currently supports grants for several statutorily-defined community programs administered by the Division of Mental Health and Substance Abuse Services.

The current transportation fund appropriation for the program, which has base funding of $731,600, would be eliminated. As no additional funding would be provided for DHS to support the pretrial intoxicated driver intervention grant program, the Department would make grants for all programs supported from the appropriation, including the transferred program, from base funding for the appropriation ($8,681,100 annually). The bill would not specify an annual amount DHS would be required to provide under the pretrial intoxicated driver intervention grant program. The fiscal effect of the elimination of the DOT appropriation and additional information about the pretrial intoxicated driver intervention grant program is provided under "Transportation."

[Act 55 Sections: 656, 692, 2595, and 4349]

10. WISCONSIN WELL WOMAN PROGRAM

GPR	$100,000

Joint Finance/Legislature: Provide a one-time funding increase of $100,000 GPR in 2016-17 for the Wisconsin Well Woman Program, which funds breast and cervical cancer screenings for women in low-income families without access to other insurance coverage. In 2014-15, funding for that program equaled $2,228,200 GPR and $3,291,900 FED.

11. ADVANCED LIFE SUPPORT TRAINING GRANT

	Jt. Finance/Leg. (Chg. to Gov)	Veto (Chg. to Leg)	Net Change
GPR	$40,000	- $40,000	$0

Joint Finance/Legislature: Provide $20,000 in each year of the 2015-17 biennium for a grant, provided on a one-time basis, for an entity that provides or facilitates advanced life support training to physicians, physician's assistants, nurse practitioners, registered nurses, and emergency medical technician - paramedics, who work in rural areas of the state.

Veto by Governor [E-77]: Delete provision.

[Act 55 Vetoed Sections: 481, 668r, 668s, 9118(3q), and 9418(7q)]

12. AMBULANCE STAFFING OF PARAMEDICS

Joint Finance/Legislature: Provide that, if an ambulance service provider initially licensed at the paramedic level in 1993 and located in a municipality in Dodge and Jefferson Counties has dispatched an ambulance containing two emergency medical technicians-paramedics ("paramedics"), permit that provider to staff an ambulance at the paramedic level for a subsequent call with one paramedic and one emergency medical technician of any level while the first ambulance containing two paramedics is occupied providing service. This would apply to such ambulance service providers located in Watertown.

[Act 55 Sections: 4109j and 4019k]

13. LEAD-BEARING PAINT -- DEFINITIONS AND PENALTIES

Joint Finance/Legislature: Change the definition of "lead-bearing paint" (from the current law definition of any paint or other surface coating material containing more than 0.06% lead by weight in liquid paint or more than 0.7 milligrams of lead per square centimeter in the dried film of applied paint) to any paint or other surface coating containing more than 0.06% by weight in liquid paint, more than 0.5% lead by weight in dried paint, or 1.0 milligram of lead per square centimeter in dried paint. Delete a current law provision that allows administrative rules to supersede the statutory definition of "lead-bearing paint" if the Centers for Disease Control and Prevention specifies a standard that differs from state statute.

Increase the forfeiture for a violation of statutes relating to ss. 254.11 to 254.178 of the statutes, or rules promulgated, or orders issued, under those sections from not less than $100 nor more than $1,000, to not less than $100 nor more than $5,000 per violation. Specify that the criminal penalty for a person who knowingly violates any provision of ss. 254.11 to 254.178, or any rule promulgated, or order issued, under those sections is not less than $100 nor more than $5,000 per violation (current law does not specify that the penalty is per violation). Specify that these provisions would first apply to violations that occur on the bill's general effective date. These penalties apply to the use or sale of lead-bearing paint, and the prevention and control of lead-bearing paint hazards.

[Act 55 Sections: 4045p, 4048d thru 4049e, and 9318(1v)]

Departmentwide

1. STANDARD BUDGET ADJUSTMENTS

	Funding	Positions
GPR	$8,159,900	- 0.75
FED	922,700	- 0.75
PR	6,662,000	0.00
SEG	- 22,200	0.00
Total	$15,722,400	- 1.50

Governor/Legislature: Provide $7,763,300 ($4,026,700 GPR, $433,800 FED, $3,314,100 PR and -$11,300 SEG) in 2015-16 and $7,959,100 ($4,133,200 GPR, $488,900 FED, $3,347,900 PR, and -$10,900 SEG) in 2016-17, and a reduction of 1.5 positions (-0.75 GPR positions and -0.75 FED positions) beginning in 2015-16, to reflect the following standard budget adjustments: (a) turnover reduction (-$2,935,100 GPR, -$1,658,500 FED, and -$2,207,000 PR annually); (b) removal of noncontinuing items (-$805,000 GPR and -$55,000 FED annually, and -0.75 GPR position and -0.75 FED position beginning in 2015-16); (c) full funding of continuing salaries and fringe benefits ($2,877,700 GPR, $2,982,400 FED, -$524,800 PR and -$8,700 SEG annually); (d) overtime ($1,943,700 GPR and $4,120,500 PR annually); (e) night and weekend salary ($1,913,600 GPR, $101,400 FED, and $2,427,000 PR annually); (f) lease costs ($1,031,800 GPR, -$936,500 FED, -$501,600 PR, and -$2,600 SEG in 2015-16, and $1,138,300 GPR, -$881,400 FED, -$467,800 PR and -$2,200 SEG in 2016-17); and (g) minor transfers within appropriations.

2. ELIMINATE LONG-TERM VACANCIES [LFB Paper 385]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
GPR	- $1,064,400	- 7.86	$0	0.00	- $1,064,400	- 7.86
FED	0	- 25.39	- 3,428,000	0.00	- 3,428,000	- 25.39
PR	0	- 3.25	- 304,800	0.00	- 304,800	- 3.25
Total	- $1,064,400	- 36.50	- $3,732,800	0.00	- $4,797,200	- 36.50

Governor: Reduce funding by $532,200 GPR annually and delete 36.5 positions (-7.86 GPR positions, -25.39 FED positions, and -3.25 PR positions), beginning in 2015-16, as part of the administration's initiative to eliminate positions that have been vacant for more than 12 months and reduce funding associated with the deleted GPR- funded positions.

Joint Finance/Legislature: Reduce funding by $1,714,000 FED and $152,400 PR annually to delete the funding associated with the FED and PR position authority deleted under the Governor's recommendations. The following table shows the position and funding reductions by DHS program and appropriation.

Appropriation, By DHS Division	Fund Source	Positions	Funding
Public Health			
General Program Operations	GPR	-0.23	-$15,600
State Vital Records Office	PR	-2.00	-92,800
Interagency and Intra-agency Programs	PR	-0.45	-21,000
MA Administration	FED	-0.20	-13,600
WIC Operations	FED	-0.15	-7,000
Federal Project Operations	FED	-13.37	-1,008,200
Preventive Health Block Grant - Operations	FED	-0.47	-21,800
Maternal and Child Health Block Grant - Operations	FED	-3.08	-156,500
Institutions			
General Program Operations	GPR	-0.60	-$22,100
Alternative Services of Institutes and Centers	PR	-0.40	-22,700
Centers for Developmentally Disabled - Operations	PR	-0.40	-15,900
Medicaid Services			
General Program Operations	GPR	-3.83	-$238,100
MA Administration	FED	-1.02	-70,000
FoodShare Administration	FED	-2.40	-146,600
Disability Determination	FED	-1.00	-43,000
Quality Assurance			
General Program Operations	GPR	-0.45	-$20,900
Medicare - State Administration	FED	-0.18	-8,400
MA Survey and Certification	FED	-0.27	-12,600
Disability and Elder Services			
General Program Operations	GPR	-1.00	-$73,600
MA Administration	FED	-1.00	-73,600
General Administration			
General Program Operations	GPR	-1.75	-$161,900
Federal Program Operations	FED	-1.25	-84,800
Indirect Cost Reimbursements	FED	-1.00	-67,900
Total		-36.50	-$2,398,600

3. FEDERAL REVENUE REESTIMATE [LFB Paper 386]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
FED	$53,068,800	- $14,836,800	$38,232,000

Governor: Provide $24,608,500 in 2015-16 and $28,460,300 in 2016-17 for funding adjustments to federal appropriations that are not included under other items.

Joint Finance/Legislature: Reduce estimates of federal funding DHS allocates to income maintenance consortia by $6,918,400 FED in 2015-16 and by $7,918,400 FED in 2016-17. This adjustment would be made, instead, under the income maintenance item under Medical Assistance -- Administration. The following table shows the base funding amount for each appropriation affected by this item, the funding change under this item, the MA funding changes under other items in Act 55, and the total amount budgeted in each appropriation.

		2015-16			2016-17		
Appropriation, by Division	2014-15 Base Funding	Reestimate	Other Items	Total	Reestimate	Other Items	Total
Public Health							
Preventive Health Block Grant	$1,625,400	$532,200	$307,700	$2,465,300	$532,200	$307,700	$2,465,300
Maternal and Child Health Block Grant	6,071,700	427,000	0	6,498,700	427,000	0	6,498,700
Medicaid Services							
FoodShare Administration	5,557,500	9,120,600	296,700	14,974,800	10,120,600	296,700	15,974,800
MA Administration - Family Care	21,165,800	7,834,200	0	29,000,000	8,834,200	168,000	30,168,000
Mental Health and Substance Abuse							
Mental Health Block Grant (MHBG)	5,922,500	-443,100	-9,700	5,469,700	-443,100	-9,700	5,469,700
Substance Abuse Block Grant	27,891,900	-92,900	35,800	27,834,800	-92,900	35,800	27,834,800
Project Operations	136,400	296,300	4,900	437,600	296,300	4,900	437,600
Project Aids	937,300	-602,700	0	334,600	-602,700	0	334,600
MHBG Block Grant - Local Assistance	2,100,400	9,100	0	2,109,500	9,100	0	2,109,500
Disability and Elder Services							
Program Aids	27,875,700	1,124,300	298,700	29,298,700	2,124,300	298,700	30,298,700
Social Services Block Grant	21,681,000	-1,765,600	1,326,600	21,242,000	-1,858,700	1,258,600	21,080,900
General Administration							
Indirect Cost Reimbursement	2,658,500	936,500	-880,200	2,714,800	881,400	-825,100	2,714,800
Office of the Inspector General	250,000	314,200	0	564,200	314,200	0	564,200
Total		$17,690,100			$20,541,900		

4. FUNDING AND POSITION TRANSFERS [LFB Paper 387]

	Funding	Positions
GPR	- $708,800	0.00
FED	- 1,071,200	- 5.05
PR	1,067,000	5.05
Total	- $713,000	0.00

Governor/Legislature: Decrease funding by $356,500 (-$354,400 GPR, -$535,600 FED and $533,500 PR) annually, and convert the funding sources for current positions to create a net increase of 5.05 PR positions and a net decrease of 5.05 FED positions, beginning in 2015-16. These transfers are intended to budget current base positions from appropriations that better reflect the current activities of these positions, and to reflect internal transfers of positions that occurred in the 2013-15 biennium. The following table identifies the funding and position transfers under this provision.

DHS Administrative Transfers
Annual Funding Changes, and Position Changes Beginning in 2015-16

	Fund Source	Funding	Positions
Public Health			
General Program Operations	GPR	$100	0.00
Vital Records	PR	202,500	1.53
Interagency and Intra-agency Programs	PR	330,000	3.12
Federal Projects Operations	FED	-647,400	-5.40
Federal Preventive Health Block Grant - Operations	FED	64,800	0.65
Maternal and Child Health Block Grant - Operations	FED	32,700	-0.12
Federal Women, Infants and Children (WIC) Program - Operations	FED	17,300	0.22
Mental Health and Developmental Disabilities Facilities			
General Program Operations	GPR	-$149,300	-2.00
Alternative Services of Institutes and Centers	PR	-77,500	-1.80
Institute Operations	PR	-78,500	-1.10
Power Plant Operations	PR	67,300	1.00
Centers for Persons with Developmental Disabilities - Operations	PR	247,800	3.80
Interagency and Intra-agency Programs	PR	-118,200	-1.00
Medicaid Services			
General Program Operations	GPR	-$195,600	-2.52
Federal Program Operations - FoodShare Administration	FED	-32,000	-0.58
Medical Assistance - State Administration	FED	-161,500	-1.90
Mental Health and Substance Abuse Services			
General Program Operations	GPR	$145,700	2.00
Interagency and Intra-agency Programs	PR	39,800	0.50
Federal Block Grant Operations - Substance Abuse Block Grant	FED	-33,000	-0.40
Community Mental Health Block Grant - Operations	FED	-45,100	-0.50
Federal Program Operations - MA State Administration	FED	53,100	0.50
Quality Assurance			
General Program Operations	GPR	$3,400	0.00
Health Facilities License Fees	PR	-29,300	0.00
Licensing and Support Services	PR	1,700	0.00
Federal Program Operations	FED	-22,200	-0.20
Medicare - State Administration	FED	182,800	2.00
Medical Assistance Survey and Certification Operations	FED	-138,700	-1.80
Disability and Elder Services			
General Program Operations	GPR	-$354,400	0.00
Interagency and Intra-agency Programs	PR	-52,100	-1.00
Federal Project Operations	FED	-83,200	-1.00
Medical Assistance - State Administration	FED	-28,300	-0.30
Federal Program Operations - Aging Program Operations	FED	111,500	1.30
General Administration			
General Program Operations	GPR	$195,700	2.52
Bureau of Information Technology Services (BITS)	PR	3,500,000	0.00
Information Technology - Divisional Purchases from BITS	PR	-3,500,000	0.00
Federal Program Operations	FED	193,600	2.48
Medical Assistance - State Administration	FED	-494,200	-5.15
FoodShare Administration	PR	494,200	5.15
Total		**-$356,500**	**0.00**

5. PROGRAM REVENUE FUNDING ADJUSTMENTS

PR	$7,355,300

Governor/Legislature: Provide $3,782,100 in 2015-16 and $3,573,200 in 2016-17 to reflect the net effect of funding adjustments to program revenue appropriations. The following table shows the base funding amount for each appropriation, the funding change under this item, the net funding changes to these appropriations under other items in Act 55, and the total amount budgeted in each appropriation.

		2015-16			2016-17		
Appropriation, by Division	2014-15 Base Funding	Funding Adjustment	Other Items	Total	Funding Adjustment	Other Items	Total
Public Health							
Health Care Information	$1,595,900	$404,100	-$261,900	$1,738,100	$0	-$261,900	$1,334,000
WIC Administration	84,000	-35,800	0	48,200	-35,800	0	48,200
Interagency and Intra-agency Programs	2,752,900	1,034,700	341,400	4,129,000	1,034,700	341,400	4,129,000
Interagency and Intra-agency Aids	914,700	-814,700	0	100,000	-814,700	0	100,000
Congenital Disorders	325,800	176,200	0	502,000	176,200	0	502,000
Institutions							
State Institute Operations	31,990,100	2,198,500	9,209,400	43,398,000	2,198,500	8,404,800	42,593,400
Extended Intensive Treatment	500,000	-400,000	0	100,000	-400,000	0	100,000
Medicaid Services							
SeniorCare Enrollment Fees	2,769,100	1,400,000	11,700	4,180,800	1,400,000	11,700	4,180,800
Chronic Disease Program - Drug Rebates	610,000	490,000	0	1,100,000	590,000	0	1,200,000
MA Administration - Enrollment Fees	5,530,200	-3,500,000	0	2,030,200	-3,500,000	0	2,030,200
MA Provider Audits and Reviews	0	206,500	19,200	225,700	228,400	19,200	247,600
Interagency and Intra-Agency Programs	4,848,400	1,400,000	654,900	6,903,300	1,400,000	654,900	6,903,300
Mental Health and Substance Abuse Services							
Gifts and Grants	274,700	-141,600	600	133,700	-141,600	600	133,700
Interagency and Intra-agency Programs	2,902,100	477,700	82,500	3,462,300	556,800	82,500	3,541,400
Disability and Elder Services							
Cost Recoveries	371,800	-287,500	-84,300	0	-287,500	-84,300	0
Gifts and Grants	136,000	140,100	-276,100	0	134,100	-270,100	0
Children's Long-term Support Waivers	653,300	913,800	-1,567,100	0	914,000	-1,567,300	0
General Administration							
OIG Interagency and Intra-agency Programs	293,600	120,100	17,500	431,200	120,100	17,500	431,200
Total		$3,782,100			$3,573,200		

6. TRANSFER VACANT POSITION TO DEPARTMENT OF ADMINISTRATION FOR INFORMATION TECHNOLOGY PROCUREMENT [LFB Paper 113]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
PR	- $197,200	- 1.00	$197,200	1.00	$0	0.00

Governor: Transfer 1.0 vacant position to the Department of Administration for

information technology and services procurement. Delete $98,600 annually from the DHS administrative and support services appropriation associated with the position.

Joint Finance/Legislature: Delete provision. [See "Administration -- Transfers."]

7. TRANSFER POSITION TO DEPARTMENT OF ADMINISTRATION FOR OFFICE OF GOVERNMENT CONTINUITY [LFB Paper 114]

	Governor (Chg. to Base) Positions	Jt. Finance/Leg. (Chg. to Gov) Positions	Net Change Positions
PR	- 1.00	1.00	0.00

Governor: Transfer 1.0 position to the Department of Administration (DOA) for a newly created Office of Government Continuity. Under the bill, the Office would establish and administer a continuity of government program in consultation with the administrator of the Division of Emergency Management in the Department of Military Affairs, to ensure the continuity of state government operations during a disaster. The bill does not specify the type of position to be transferred or whether incumbent employees would be transferred to DOA. Funding associated with the position ($66,500 annually) would not be reduced, but rather reallocated to supplies and services to pay Office of Continuity charges assessed by DOA.

Joint Finance/Legislature: Delete provision. [See "Administration -- Transfers."]